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***THE NEEDS AND STRATEGIES
OF THE
RACIALLY AND CULTURALLY DIVERSE
AND
FAMILY PLANNING SERVICES***

JULY 1992

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RESEARCH PROJECT COORDINATOR**

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Thecla Damianakis

TABLE OF CONTENTS

Glossary of Terms

Executive Summary

Recommendations

Introduction

Objectives of the Project

Census/Statistics

1986 Census Population of Hamilton-Wentworth: By Place of Birth; By Mother Tongue

Literature Review

General Topics on Family Planning

Family Planning and the Racially and Culturally Diverse

Assumptions of the Research

Methodology

Type of Research

Key Informant Interviews

Phone Interviews

Feedback, changes and consent

Consumer Questionnaire

Cultural translation of consumer questionnaire

Agency Survey

Pilot Focus Group

Changes Made

Unsuccessful attempts at Organizing Focus Groups

Focus Groups

Process of Focus Groups

Facilitators/Cultural Interpreters chosen

Locations

Comparison between Pilot and Secondary Focus Groups

Focus groups sample

Findings

Key Informant Interviews

"Unwanted pregnancies leading to therapeutic abortions May and June 1991" Statistics by Key Informant

Consumer Questionnaire: Focus Group Participants and Spanish Participants

Agency Survey

Pilot Focus Group Highlights

Focus Group Discussions

Birth control and family planning experiences

Urban versus Rural influences

Economics and Family Planning

Identification of Cultural and Religious Norms

Attitudes towards various Birth Control Methods

Attitudes towards Abortion
Attitudes towards Infertility
Circumcision
Attitudes towards AIDS and Sexually Transmitted
Diseases
The Medical and Social System here (responsiveness
to and flexibility of)
NEEDS identified

Evaluation of Focus Group Sessions, by participants

Additional Data Obtained:

Professionals' feedback
Facts of Life Line
Questions posed by participants

Discussion and Summary of Report:

Objectives Achieved
Myths Dispelled by the Research
Factors Affecting Family Planning
Main Issues Confirmed

Future Direction

Agency Mailing and Key Informant Listings

References

Appendices:

- A-1. 1986 Census, Total Population of Hamilton-Wentworth, By
Place of Birth
- A-2. 1986 Census, Total Population of Hamilton-Wentworth,
By Selected Mother Tongue, Gender, and Census Division
- B. Key Informants Interview Agenda
- C. Consumer Questionnaire
- D. Agency Introduction Letter and Survey
- E. Pilot Focus Group Questions
- F. Focus Group Agenda

GLOSSARY OF TERMS

Four sources were adapted or quoted for the development of this glossary, most notably, In Fertile Ground: Women Creating Reproductive Freedom(*); Bridges of Power: Women's Multicultural Alliances(**); Diverse Racial and Cultural Group's Access to the Social Service System(***); and Action Research for Women's Groups(****).

Access: refers to one's ability to be part of the planning, implementation, and/or the use of any given service

Action-research: the systematic collection and analysis of information for the purpose of directing political action and social change****

Advocacy: speaking or acting on behalf of a person, group, or idea*

Anti-choice: the anti-choice position holds that the right to life of an embryo and/or fetus take priority over the woman's right to choose an abortion when dealing with an unplanned pregnancy

Anti-natalism: a population control policy of governments who want fewer people in their country*

Artificial Insemination: when a woman becomes pregnant by the insertion of sperm into her uterus, without having sexual intercourse; this can be done by the woman herself, or by a doctor, using sperm donated by a man whom the woman may or may not know*

Assimilation: refers to the loss of a cultural identity in order to gain social acceptance or approval by adopting the values of the dominant group

Birth control: something that is done or used by a woman or man or couple to prevent unwanted pregnancy*

Birth rate: the number of children born in a year per 1000 persons, for example, the birth rate in Canada in 1985 was 14.8*

Celibacy: choosing not to have sexual relations*

Circumcision: the cutting around or removal of the foreskin of the penis or the cutting of the clitoris, removing the outer labia (lips) and closing with stitches; this practice is often dangerous resulting in permanent damage and problems for the woman

Class, social classes: levels of society that have different amounts of money and power (decision-making privilege)*

Coerce: to bribe, force, or pressure someone into an action or decision that is not really wanted*

Contraception: prevention of pregnancy (same as birth control)*

Culture: refers to the complete lifestyle of a community or a group of people--which includes their beliefs, and ideas on various issues, for example, family, employment, education, religion, health, economics

Cultural conflict: refers to the struggle between two cultures. Often, this is between one's cultural norms which differ from the mainstream norms and often creates feelings of confusion and alienation; this conflict includes the frustration of being in the oppressed group and not the dominant group.

Cultural Interpreter: refers to an individual who, coming from a particular racial or cultural background and knowing that language and culture, translates the words and the meanings of those words to others not from that racial or cultural group

Depo-Provera: a long-acting hormone contraceptive administered by injection; while removed for contraceptive use in Canada and the United States because of possible increased risks to cancers and delayed return of fertility, depo-provera is widely used in 80 countries around the world*

Disadvantaged: not having the same opportunities as other people*

Discrimination: unfair treatment based on prejudice, [or hateful attitudes]; people may be discriminated against for reasons, including the colour of their skin, their religion, or their sex, [etc.]*

Disincentives: punishments that discourage people from certain actions or decisions, for example, in population control programs food, education, housing are used in exchange for birth control use

Empower/empowerment: when people learn to have power in themselves to control their own lives; we can empower ourselves and we can help others empower themselves [at an individual or social level]*

Ethnicity: refers to groups which share a common culture, language, religion, or national origin

Ethno-Specific Organizations/Agencies: refers to organizations geared to primarily serving one or more ethno-cultural groups (although they may not exclude serving others from the general community)***

Family: refers to the primary care giving unit composed of two or more people

Family Planning: refers to services that help women and/or men, who want to plan for children, space their children, limit their family size, or prevent unwanted pregnancy. Birth control is a preventive approach to unwanted pregnancy, based on self-identified needs. Family planning services are often but not exclusive to birth control. Family Planning programs differ from population control programs, in intent and in implementation.

Feminism: refers to a set of beliefs about women in society, including the oppression of women and need to struggle against that oppression

Fertility: ability to get pregnant*

Focus groups: a method to collect information, whereby values, beliefs and experiences are discussed in order to reach an understanding; everyone has equal decision making power and the group arrives at a consensus (agreement) on an issue and how to get needs met

Generic Organizations/Agencies: are those that offer services to the general population, according to eligibility criteria that do not emphasize membership in a specific ethno-cultural group; also referred to as 'mainstream' agencies***

Global to Local thinking: the belief that there exists a social and political relationship (often of an oppressive nature) between what occurs/exists abroad and what occurs/exists here; the opposite (local to global thinking) refers to the belief that what occurs/exists in Canada also occurs/exists abroad

Incentives: rewards that encourage people to do something, for example, in population control programs, women may be given food, clothing or money if they accept birth control (often including sterilization)*

Internalized domination: internalized domination is the incorporation and acceptance by individuals within a dominant group of prejudices against others**

Internalized oppression: internalized oppression is the incorporation and acceptance by individuals within an oppressed group of the prejudices against them within the dominant society**

In Vitro Fertilization (IVF): literally means fertilization in a glass dish and is usually called "test tube baby"; it is a method for getting pregnant where a woman's egg is fertilized outside her body and then put into her womb by way of a surgical procedure*

Local to Global thinking: the belief that there exists a social and political relationship (often of an oppressive nature) between what occurs/exists in Canada and what occurs/exists in other countries; the opposite (global to local thinking) refers to the belief that what occurs/exists abroad also exists here

Multiculturalism: refers to the official ideology of cultural pluralism, where all cultures have equal status and merit in Canadian society, and none has more power than another. Multiculturalism policies promote integration, not assimilation, of minority groups into society.*** Multiculturalism is a state defined term as oppose to a self-defined term by the various racial and cultural groups. Differences in ideology and reality, however, can and do occur.

Natural Family Planning: the ability to prevent pregnancy through careful attention to changes in a women's body which indicate what time of the month she is most likely to get pregnant

New Reproductive Technology: the mostly technical and expensive methods that can help some women to become pregnant and have children; for example, artificial insemination, and surrogate motherhood*

Overpopulation: when a country or place has more people than it can feed and take care of;* this term, when not supported by quality census collection and population projections, as well as an understanding of the lifestyles of the country, can be misused to justify population control programs

Patriarchy: the social system of men over women, in which women are denied social, political, sexual and economic control; this system is rooted in the belief of women's inferiority to men, which is reinforced by male force and violence**

Politics: [in slang terms] refers to the desire or need to elevate one's position at the expense of another position

Population Control: when governments or other powerful groups try to control the birth rate of a country or group by influencing how many children people have; in some third world countries governments do this by providing rewards when women take birth control or punishing them when they refuse*

Prejudice: the belief that someone is inferior based on their race, religion or sex*

Pro-choice: the pro-choice position holds that women have the right to make their own reproductive choices ie. every woman has a right to choose whether she wants to get pregnant or not; whether she wants to carry on with a pregnancy or not, and that there should be safe and legal access to abortion services available for all women*

Racism/racist: thinking or acting on the belief that another culture or race of people is inferior;* subtle racism hides this belief in a way which makes it harder to detect

Racially and Culturally Diverse: for the purpose of this research, racially and culturally diverse persons includes immigrants, refugees, and aboriginal people; this differs from "multicultural" in referring to immigrants and refugees and not aboriginal people

Reproduction: everything that is related to the fact that women can have children; this includes menstruation, getting pregnant or not, giving birth*

Sexism: the belief in the inherent superiority of men and therefore, their right to dominance**

Sexual orientation: preference of sexual partner by gender*

Sterilization: a surgical procedure which prevents pregnancy, usually considered permanent*

The Third World/Two-Thirds World: the countries of Africa, Asia, Latin America and the Pacific where many of the people are poor and don't have enough money to buy food, clothes and other things they need; the second term relates to the first, but describes the fact that those countries make up two thirds of the world

EXECUTIVE SUMMARY

Introduction

An individual's ability to plan in favour of having children or plan to prevent an unwanted pregnancy is a fundamental aspect in creating a community where healthy sexual behaviour is practised and supported. Given the heightened awareness regarding immigrant and refugee issues in mainstream society recently, and the proven need for greater accessibility to the social service and health care systems locally, the Planned Parenthood Society of Hamilton became increasingly aware that its client population did not reflect the racially and culturally diverse population of the region, and perhaps, that some needs were not being addressed in this community.

Accepting that for many immigrant or refugee women, there are additional factors which would prevent access to all community and health services, including:

- * language barriers,
- * discrimination,
- * financial difficulties,
- * transportation unfamiliarity,
- * sexism, and
- * differences in religious and cultural norms in relation to mainstream agencies, such as Planned Parenthood,

a project was initiated to determine the needs (if any) of various racially and culturally diverse groups for family planning services.

The term 'family planning', as an inherently Western concept, refers to services that help women and/or men who want to plan for children, space their children, limit their family size, or prevent unwanted pregnancy. Birth control is a preventative approach to unwanted pregnancy, based on self-identified needs. Family planning services are often but not exclusive to birth control.

Purpose

The main purpose of this project was to identify, through the active participation of as many racially and culturally diverse people as time permitted, the family planning needs (if any) of their communities in Hamilton, and to establish strategies to meet those needs.

The project established seven main objectives in attempting to understand the reality of racially and culturally diverse women's lives (and men's responsibility to family planning) in relation to family planning, birth control, and sexuality issues. More specifically, the objectives of the study were:

- 1) To listen to and understand racially and culturally diverse peoples' past and present experiences in relation to family planning.
- 2) To identify and understand possible factors (socio-economic, systemic, cultural and religious norms) which may affect family planning decisions.
- 3) To understand attitudes towards various methods of birth control.
- 4) To identify if family planning services currently exist for Hamilton's racially and culturally diverse communities.
- 5) To identify barriers to accessing services in family planning.
- 6) To identify the needs of the communities regarding family planning/sexuality issues.
- 7) To identify goals and changes that need to be made, while creating solutions/action.

Canadian Context

Planned Parenthood of Manitoba, in collaboration with the Vietnamese, Cambodian, Chinese, and Latin American communities, has developed a comprehensive, community based immigrant and refugee health program over the past five years. Planned Parenthood of Ottawa is providing educational sessions dealing with multiculturalism and sexuality, as well as services to the Somali and Spanish-speaking communities. Planned Parenthood of Toronto offers the Facts of Life Line (a confidential telephone information line) in Spanish.

General Literature Topics on Family Planning

The general theme which occurs in the literature is that sexuality issues are complex, and influenced by a variety of factors: socio-economics, religion, education, sexism, marital status, and the ability to access birth control services. In Western thinking, sexuality and birth control issues often give mixed messages: the media often promotes sex with violence and rarely in a positive manner promoting healthy responsible sexual behaviour. More specifically, the literature on the use of birth control tends to support two perspectives, namely, the conservative view in which birth control is a means of state population control, as opposed to the liberal view that birth control is a right and a means for a woman to control her own body and lifestyle. Furthermore, the literature has documented the relationship between an unwanted or unplanned pregnancy and need for abortion; and the impact of birth control and family planning services as a preventative measure.

Literature on Family Planning and the Racially and Culturally Diverse

Once again the literature reflects varying viewpoints. One view has tended to indicate the use of birth control and family planning services as a means of empowerment for women leading to possible options and choice. The opposing view has tended to reflect the use of birth control as a means used by governments to control the number of children in a family thereby controlling the numbers and economic resources of a particular cultural and/or racial group. Often there is a distinction drawn between family planning and government population control programs: family planning services help women and/or men plan for or prevent children through the presentation of all options, while population control programs try to control the birth rate of a country through rewards and punishment. Problems and confusion have arisen when the terms are used interchangeably to describe two fundamentally different concepts--both in philosophy, and in the means of implementation. The important distinction noted is that family planning services empower; while population control, as the name suggests, oppresses.

Methodology

This research is primarily qualitative and action research principles guide the process of collecting information. As such it begins with the belief that the state of reality is diverse and subjective, and that people must be active in their own change processes.

These beliefs are consistent with the purpose of this study, to understand the needs of various racially and culturally diverse groups through their past and present family planning experiences, and to begin to strategize for long-term changes, both at a community level and at a systems level.

Specifically, 82 agency questionnaires were distributed, 34 key informant interviews conducted, 5 phone interviews conducted, 70 consumer questionnaires completed (45 from focus group participants and 25 independent of the focus groups, all representing the Spanish community), and there were 50 focus group participants representing the Vietnamese, Cambodian, Portuguese, Chinese, Somalian, and East Indian communities.

All those individuals who participated in the focus groups and consumer questionnaires were born outside Canada, 98% from countries representative of their cultural origins, having obtained various statuses while in Canada. Key informants included immigrants, refugees and aboriginal people.

HIGHLIGHTS OF FINDINGS

Included below are the highlights of the comments, concerns and views of those people who participated in this project:

- * Planned Parenthood services were not known amongst racially and culturally diverse focus group participants,
- * contrary to stereotypes, racially and culturally diverse participants showed similar knowledge base of family planning methods to the general population,
- * contrary to stereotypes, racially and culturally diverse women are interested in family planning services and issues,
- * contrary to stereotypes, racially and culturally diverse women do not have or want 'large' numbers of children in Canada,
- * contrary to stereotypes, participants in this research stressed that abortion was not approved as a method of birth control by their religions or cultures,
- * when speaking about their past, most focus group participants said that natural family planning was usually the only method available to them, and that when artificial family planning devices became available, they were difficult to access,
- * a barrier in accessing family planning services in Canada is often established for those who have had oppressive reproductive health experiences in their country of origin,
- * immigrant and refugee women said some of their cultural and religious values, beliefs and customs set limitations on their family planning decisions,
- * many racially and culturally diverse people feel they must abandon the traditional values, which promote 'large' families, because of the economic hardships faced in Canada,
- * when describing their countries of origins, participants said urban centres tend to provide greater access to services (health care and reproductive) than in a rural setting,
- * those with greater financial resources have more options of birth control methods available to them; for example, in their countries of origin the condom and the IUD were less expensive and more accessible than oral contraceptives,
- * while family planning is most often seen as primarily the women's responsibility, some women experienced pressures and restrictions around reproductive choices from their male partners,

- * some men, who traditionally held power and authority over women, are having difficulty accepting the role and rights women can have in Canadian society,
- * most of the focus groups said doctors who speak their first language are not available in Hamilton and that effective interpreters are not available,
- * participants were more likely to use birth control methods upon arrival in Canada,
- * mainstream values and policies restrict or deny access to services for many racially and culturally diverse groups,
- * settlement in a new country is often very stressful and affects many aspects of an individual's life--including the ability to plan for and conceive children,
- * therapeutic abortion statistics, provided by a key informant, confirm racially and culturally diverse women experience unwanted pregnancies,
- * 71% of the agencies completing the agency questionnaire agreed there is a need for family planning information and services appropriate for the racially and culturally diverse communities in Hamilton,

Needs Expressed by Focus Group Participants

- * written and verbal education and information on family planning options, including their risks and benefits of birth control devices, which is sensitive to cultural and religious values,
- * assistance in reaching those most isolated in their communities,
- * assistance with birth control costs,
- * assistance in understanding and accessing the medical and social service systems, including family planning programs,
- * assistance in involving men to participate equally in family planning decisions,
- * racial and cultural sensitivity from current workers in the system,
- * assistance with transportation cost,
- * to be actively involved in program planning by participating on the board and committees of Planned Parenthood.

RECOMMENDATIONS

1. That Planned Parenthood Society of Hamilton in collaboration with racially and culturally diverse communities translate the current Facts of Life Line into all the necessary languages, ensuring cultural and religious sensitivity.

All the focus groups recommended that the Facts of Life Line be transcribed from its current English form to their own languages. The confidential nature of this service was strongly supported by the groups.

2. That Planned Parenthood Society of Hamilton, in collaboration with racially and culturally diverse communities, develop pamphlets on the available methods of birth control in Canada, balancing natural family planning with artificial birth control methods, and outlining the risks and benefits of all methods. The pamphlets should be written in various languages, particularly Khmer and Somali, with cultural and religious sensitivity, and at an appropriate literacy level.

Currently, the Ministry of Health circulates pamphlets in a variety of languages outlining the methods of birth control available in Canada, including natural and artificial methods. These pamphlets were handed out during this process to service providers and to focus group participants, except to the Cambodian and Somali groups since written material does not exist in Khmer and Somali languages.

3. That Planned Parenthood Society of Hamilton, in collaboration with various racially and culturally diverse communities, establish community outreach workers representing each of the communities identified, to provide appropriate information, advocacy, and services for their own communities through educational sessions, home visits and assistance with clinic translation when necessary.

There was consensus within all the focus groups that individuals from their own communities be active in educating their communities as to family planning issues. There was further consensus that individuals felt this would be the only way to ensure understanding and respect of their religious and cultural norms. Furthermore, focus groups wanted to learn more about the specifics of birth control methods available in Canada from Planned Parenthood staff, while the final "front-line" educating of the communities would be provided by the representatives of those communities.

4. That Planned Parenthood Society of Hamilton, in collaboration with racially and culturally diverse communities, design brochures in various languages regarding availability of information and services of Planned Parenthood.

Focus group participants were not familiar with Planned Parenthood Society of Hamilton's services, while some said they would have used this service had they known about it. Furthermore, many cited the need and desire for assistance in accessing the medical and social service systems, in general.

5. That Planned Parenthood Society of Hamilton, in collaboration with the community outreach workers, conduct inter-generational educational/communication sessions for various racially and culturally diverse groups.

In focus groups where the participants included the parents and their teenagers, the desire for improved communication between generations was identified by those participants.

6. That Planned Parenthood Society of Hamilton seek funding to identify and eliminate any systemic barriers which may restrict access to its services or organization.

This recommendation arose from agency personnel whose organizations have attempted to expand their mainstream services to be inclusive of racially and culturally diverse people.

7. That Planned Parenthood Society of Hamilton ensure that the culturally and racially diverse groups of the Hamilton-Wentworth community are represented at all levels of the organization, including the establishment of an Advisory Committee with responsibility for overseeing the programs as listed in these recommendations.

Ownership of this program must come from the communities themselves if real change is to occur. Planned Parenthood can provide the expertise in sexuality education; focus group participants were interested in gaining further information from the agency's staff. The community educating would be the responsibility of the community outreach workers; and overseeing of this particular programming would be the responsibility of the racially and culturally diverse advisory committee.

8. That Planned Parenthood Society of Hamilton establish broad policies encouraging the hiring of a variety of racially and culturally diverse persons.

Previous literature and studies have supported the need for active changes in hiring practices to effectively provide access to services.

9. That Planned Parenthood Society of Hamilton continue to increase its knowledge and sensitivity to the specific racial, cultural and religious characteristics of the communities identified in this research, through the implementation of cross cultural training for staff and volunteer training conducted by representatives describing their own communities.

Focus groups identified that they often do not feel understood when attempting to access health and social services.

10. That Planned Parenthood Society of Hamilton continue to listen to the needs of various culturally and racially diverse groups seeking to work with other communities not covered in this research.

The following groups were identified but not approached to participate, due to time limitations: Polish, Italian, African, Sri-Lankan communities.

Furthermore, this study was not able to determine the needs (if any) of the Native community. Although interviews were conducted with Native key informants, attempts to organize focus groups were limited due to time constraints of the research.

11. That Planned Parenthood Society of Hamilton further research and initiate, where supported, programs which would increase men's responsibility to family planning and birth control, while breaking down machismo and sexist attitudes. It is further recommended that this research would best be achieved employing a non-sexist male researcher.

This recommendation was a recurring theme from all sources.

12. That Planned Parenthood Society of Hamilton support initiatives ensuring equality of opportunity (educational, employment etc), and availability of racially and culturally diverse doctors, nurses, and other health and social service providers, generally, and in the field of family planning.

The broader social and political issue here is one of equality, and equality of opportunity. It is necessary that each smaller agency involve itself in the broader issues which are very much related to the objective of universally accessible, and racially and culturally appropriate, family planning services.

13. That Planned Parenthood of Society of Hamilton actively support changes to oppressive government control programs abroad, in conjunction with other individuals/organizations, hence working towards the elimination of forced sterilization, and other coercive measures implemented falsely in the name of family planning.

Some key informants described the oppressive conditions experienced by their clients while in their countries of origin, in relation to reproductive issues. Some members of the focus groups described cases of material exchanges for the use of birth control, the use of Depo-Provera without the full information of its possible side effects, and regretted sterilizations.

14. That Planned Parenthood Society of Hamilton work with other organizations (generic as well as ethno-specific in nature) regarding its role in family planning with the racially and culturally diverse communities.

A long term working relationship with each of the racially and culturally diverse communities and other professionals is necessary, in ensuring agency accountability to each of the communities, and the community at large. Agency personnel identified the need for Planned Parenthood to liaise with such groups as the Immigrant Serving Inter-agency Network, the Cultural Interpreters Advisory Committee, Ontario Welcome House, the Multicultural Centre, English as a Second Language Classes, and other ethno-specific agencies in the region.

INTRODUCTION

It is only in recent years that the racially and culturally diverse communities of Hamilton have been able to generate an increased awareness in mainstream agencies of the systemic barriers to services. It has been well documented that immigrant, refugee and aboriginal populations have been excluded not only from service delivery, but also in the planning, development and organization of mainstream services.

In 1990, Planned Parenthood sought to determine if its consumer population reflected the racial and cultural diversity of the community it served. As in most health and social service agencies, statistics by ethnicity were not available. However, the general consensus of Planned Parenthood staff and volunteers was that while some individuals representing the various cultural and racial groups did access the services of the Society, there appeared to be some groups which were under-represented or not represented at all.

Simultaneously, consultation with individuals from the community began to consider the possible role and responsibility of Planned Parenthood to these communities.

Furthermore, of those racially and culturally diverse individuals accessing family planning services, certain common skills were evident, most notably: some ability to speak English or have a translator present; some comfort in approaching mainstream organizations; a preference or necessity to not go to a family doctor; a desire for a discussion format in determining what their needs were, hence involving more time. This led to the further acceptance of the likelihood that many immigrant and refugee women were not accessing the system due to barriers such as: language, discrimination, financial difficulties, transportation unfamiliarity, sexism, and differences in religious and cultural norms relating to mainstream agencies such as Planned Parenthood.

Placing this reality into its general social context regarding the numbers of unwanted pregnancies as indicated by the 1,276 therapeutic abortions of Hamilton-Wentworth residents in 1989 (Ontario Ministry of Health, Public Health Branch) led to the agreement that funds should be sought to begin to address family planning issues with Hamilton's racially and culturally diverse populations.

It was at this point that funds were sought with three assumptions at hand:

1. That racially and culturally diverse women were included in those general figures.

2. That the people best qualified to identify any needs of the racially and culturally diverse are the people from those communities.
3. That Planned Parenthood would be prepared to change the current organizational status quo should it become necessary to meet any identified needs.

With these assumptions, the general purpose of the study became clear: to identify, through the active participation of racially and culturally diverse communities, whether a need exists for family planning services which are responsive to Hamilton's diverse communities, and to establish strategies to meet any needs.

Once funding was secured for a short term project, a research coordinator was hired. The following report reflects the work of all those who were involved in creating and sharing their views and experiences on this topic, throughout the length of this project.

Objectives of the Project

- 1) To listen to and understand racially and culturally diverse peoples' past and present experiences in relation to family planning.
- 2) To identify and understand possible factors (socio-economic, systemic, cultural and religious norms etc.) which may affect family planning decisions.
- 3) To understand attitudes towards various methods of birth control.
- 4) To identify if family planning services currently exist for Hamilton's racially and culturally diverse communities.
- 5) To identify barriers to accessing services in family planning.
- 6) To identify the needs of the communities regarding family planning/sexuality issues.
- 7) To identify goals and changes that need to be made, while creating solutions/action.

CENSUS/STATISTICS

Hamilton's racial and cultural population diversity was reflected in the 1986 Census, Statistics Canada, and has its implication for the development of responsive services for the racially and culturally diverse.

In the 1986 Census Population for Hamilton-Wentworth, "Population by Place of Birth" (20% data), 24.51% (135,160) of Hamilton-Wentworth's total population (551,555) was born outside Canada. The most frequently reported locations being Europe, Asia, the Caribbean-Guyana, Africa, South America, Central America, and Australia. (See Appendix A-1)

In the 1986 Census Population for Hamilton-Wentworth, "By Selected Mother Tongue, Gender, and Census Subdivision" (100% data), 18.1% (73,435) reported mother tongues other than English or French. In relation to the groups represented in this research, 7.0% (5,105) are Portuguese-speaking, 3.1% (2,275) are Chinese-speaking, 1.5% (1,075) are Spanish-speaking, and .81% (595) are Vietnamese-speaking. Not specifically named in this listing, yet were involved in the research, are the Cambodian (Khmer) and the Somali-speaking peoples. (See Appendix A-2)

The overall trend of immigration is significant in identifying specific groups which potentially could seek family planning services. This is important in consideration of the changing Canadian society. According to Statistics Canada, The Family In Canada catalogue number 89-509), as fertility rates continue to remain at the replacement rate and immigration remains at its current rate, Canada will be a country of increasing racial and cultural diversity.

Equally important are several factors which might influence the possible need to provide family planning services, for example: the length of time since arrival, the ability to speak English and hence access the system, past experiences, the cultural and religious values, economics, the responsiveness of the current system in providing services, and the organization of the person's own community in terms of its own support system.

While the use of census is important in reflecting Hamilton's diverse population, it cannot determine whether any one group wants or needs family planning services. This reinforces the necessity to work closely with and understand the communities themselves, and establishes as the ultimate criteria for inclusion and hence representation in this project, those individuals wanting to participate.

LITERATURE REVIEW

General Literature Topics on Family Planning

The literature review in general deals with the issue of family planning from several perspectives. It highlights that sexuality issues are complex, and influenced by a variety of factors: socio-economics, marital status, religion, education, sexism, as well as the availability and accessibility of birth control services, and media influences.

Literature on Family Planning and The Racially and Culturally Diverse

This area of the literature is especially complex. Globally, it questions the moral intentions and practical implications of Western society's technology and values in Third World countries, and its relationship to economic development.

Lack of Resources

Historically, the initial wave of Western intervention in Third World countries regarding birth control use was justified by the belief that there were not adequate resources to feed the world's population if fertility continued to increase. This was supported by statistics which emphasized the relationship of poverty and hunger. Intervention began with the assumption that a decrease in fertility would increase economic development, not only in a particular country, but world-wide.

Examples were reported of many Third World women who died every year from attempting illegal abortions as a result of unwanted pregnancy and because they did not have access to contraception and other basic health care.

Need for Redistribution of Resources

This, however, was rebutted by the position that there was plenty of food for the world's population. What was needed was a redistribution of the world's resources, so that they were reaching those most in need. The initial intervention was criticized as a means for the elite in Western society to gain control of those countries' economic resources. Rooted in this rebuttal was the opposing assumption that an increase in a country's economic development would naturally lead to a decrease in fertility.

In political terms this issue became one for debate between Capitalistic, Socialist and Communist systems. Simply put, it dealt with the degree to which access to safe, appropriate, and universally affordable reproductive services existed, given inherent assumptions about the nature of each of the systems.

As more and more became known, the debate widened. No longer was the debate exclusive to one or two factors which affected fertility trends.

Eugenics

Issues of discrimination, and racism, leading to eugenics became one concern. It was argued that the fear of racially and culturally diverse persons "taking over" was a motivating force, which led to oppressive conditions for many racially and culturally diverse individuals. The implementation of some governments' population control programs forced people to limit their family size. The argument opposing eugenics stated that birth control was targeted to those who were most politically vulnerable (the poor, black, disabled, and women) so that the existing status quo could be maintained.

Population Control

The intent of population control programs, with their coercive means, strongly contrasted with the intent of family planning clinics and became evident in the means of implementation of services: forced sterilizations; the use of Depo-Provera while it was banned as a birth control method in Western society; vasectomy camps; and disincentive programs such as delivery charges at government hospitals for each additional child; less choice in the child's educational pursuits; no income tax relief; no maternity leave for later children; and/or reduced options in housing.

Family Planned Clinics

Family planning clinics goal, by contrast, was through non-coercive measures (ie. any decision to be part of the information and practice of family planning of any given society can only be taken by the members of that society in response to their needs. Outsiders can play only a marginal role.) to eliminate unwanted pregnancy. Politically, this means that family planning is not a substitute for economic development but rather part of a movement for socio-economic and political justice which actually challenges the existing status quo.

Again, the initial linear debate became more complicated when looking at the patriarchal influence in restricting racially and culturally diverse women's rights to control their own bodies. It was no longer enough to look only at the availability of resources or the economic growth of any country. The beliefs of the people became crucial in determining whether individuals planned their children or felt in control of their reproductive choices. Women who were subject to oppressive relationships, or were victims of oppressive cultural and religious values, often reinforced by a patriarchal system, did not have the same options as those whose personal values were not strongly influenced on a day to day basis by their culture, religion, or personal relationships.

Personal Values

More so than most other issues which researchers address, reproductive health and sexuality are extremely personal. In order to understand and identify family planning needs, it is imperative that personal values are taken into consideration. Personal values are rooted in the cultural, social, political, religious and economic experiences of individuals and groups. In order to provide culturally and racially sensitive services, which would include natural and artificial methods that are universally affordable and accessible and implemented without coercion, these factors must be addressed.

Risks to Women and Children

When these factors are ignored, access to services are denied, increasing risks to the health of women and children. When these factors are manipulated, for example by religious hierarchies promoting a particular stance, services are also denied, and politically oppressive conditions result. This is also true when governments manipulate these factors to justify and implement coercive programming.

ASSUMPTIONS OF THE RESEARCH

A project of this delicate nature makes inherent certain assumptions by the very nature of two juxtaposed concepts: "family planning" and the "racially and culturally diverse". These assumptions are defined in two ways: firstly, in a broader sense, and secondly, personally and in my role as researcher:

Broadly

1. The term of 'family planning' is a Western concept as it is so defined.
2. Given that it is a Western concept, certain words and concepts may not apply to any given racial or cultural group.
3. That in Western society there is a tendency towards smaller families.
4. That in Western society there is a tendency towards certain methods of birth control, particularly those which are scientifically proven to be most effective.
5. That the terms "feminism" and "choice" are Western concepts and may not be applicable to all persons from any given racial or cultural group.
6. That in Western society war, famine, and infant mortality may not have a prominent bearing on family planning decisions.
7. Given that racially and culturally diverse groups are often marginalized in society, their access to family planning services may be limited.
8. That there exist barriers for racially and culturally diverse persons to accessing family planning services: language, finances, discrimination, transportation unfamiliarity, sexism, differences in religious and cultural norms relative to mainstream agencies.
9. That mainstream organizations are inherently (given the social make-up of society) discriminatory/sexist in their structure, and need to acknowledge this and take responsibility for this to effect changes.
10. That to ignore the possibility that race, culture and religion can have an impact upon family planning decisions is ethnocentric and racist thinking, by the process of omission.

11. That there exist problems in Western society with issues of sexuality and family planning. Exploring the needs of culturally and racially diverse groups does not relieve mainstream society of its obligation to solve its own problems, nor give it any right to highlight the problems of racial or cultural groups as a way of avoiding its own problems.
12. That family planning in its broadest definition and meaning, (including natural family planning, artificial birth control, and new reproductive technologies), affects all women--lower, middle, upper-class, culturally and racially diverse, white, bisexual, heterosexual as well as lesbian.
13. That there exist in some countries population control programs with the goal to dominate and oppress.
14. That the goal of family planning services is to provide people with greater options and self-autonomy, given the reality of their lives.

Researcher's

1. All women should have control and power over their own bodies, including the option to have or not have children, and when. This power must not be controlled by the state, church, culture, economics patriarchy, and/or personal relationships.
2. That racially and culturally diverse persons wish to be treated with respect and have equal opportunities (education/employment/health care).
3. That one's health cannot be isolated from one's history and/or environment.
4. That research which is grounded in people's experiences can be a necessary means towards social change and/or political action.

METHODOLOGY

Type of Research

This research is primarily qualitative. As such it serves to maximize the views and perspectives of the groups whose opinions and views are represented. Unlike traditional forms of needs assessments, which tend to be removed from the day-to-day experiences of the people being 'studied', this project reflects the needs of the people and their experiences, as they have defined them. In this way, action research principles guide the process of collecting information.

Furthermore, every measure has been taken to eliminate racial and cultural stereotypes of any one community by allowing for varying viewpoints and maximum needs to emerge, within the focus group discussions. Feedback was obtained and changes made throughout the project to ensure the accuracy of the information and avoid misinterpretation. Information was gathered by various methods including the literature, statistics, key informant interviews, phone interviews, agency survey, consumer questionnaire, and focus groups. This variety in methods was important for two reasons: to maximize perspectives and understanding, and to offer individuals some choice in the means by which they wish to provide information. For example, some individuals were comfortable with the written form of expression, while others chose to relay their stories verbally, both in person and by phone.

Specifically, 82 agency questionnaires were distributed, 34 key informant interviews conducted, 5 phone interviews conducted, 70 consumer questionnaires completed (45 from focus group participants and 25 independent of the focus groups, all representing the Spanish community), and there were 50 focus group participants representing the Vietnamese, Cambodian, Portuguese, Chinese, Somalian, and East Indian communities.

Several forms of collecting information were used as follows:

Key Informant Interviews

Key informant interviews were conducted one-to-one with individuals, who were selected based on the following criteria with the assumption or knowledge that:

1. The individual had personal/professional insights or experience with racially and culturally diverse communities.

2. The individual had personal/professional insights or experience with racially and culturally diverse communities and family planning issues.
3. The individual had personal/professional insights or experience into socio-economics in relation to family planning.

Some key informants, after discussion, were part of the organizing of the focus groups, and in arranging a cultural interpreter, from the same community, to co-facilitate the focus group discussion.

Some key informants had both the personal experience as immigrants or refugees, and are now working for their communities, in a helping capacity and therefore were able to provide insight not only as professionals, but also from their personal experience.

Meetings were held with 34 key informants: 17 fit into category one; 14 fit into category two; and 3 fit into category three, as described above. (see Appendix B for Interview agenda).

Phone Interviews

Phone interviews were incorporated as an alternative method. This was the preferred method for 5 participants--for reasons of time limitations, comfort, and geographic distance. The results of the phone interviews are incorporated in the key informant findings.

Feedback, Changes, Consent Provided

Information obtained by phone, by key informant interviews, and by focus group discussions, were summarized and given back to the participants to carefully examine. Participants made the necessary changes to ensure that they were most accurately represented. Once this was done, a consent form was signed granting permission for this information to be incorporated into the final report.

Consumer Questionnaire

Seventy consumer questionnaires were completed, 45 of which were in conjunction with the focus group discussions, and 25, representing the Spanish community, which were completed independent of the focus groups. Consumer questionnaires were translated as necessary including: Vietnamese, Cambodian, Portuguese, Chinese, Somali, and Spanish. It was not necessary to provide translation for the East Indian focus group as all participants spoke English, in addition to their mother tongue.

The sequential numerical order of the consumer questionnaire has been altered as changes to the questionnaire content were made, based on feedback from the pilot focus group. Hence, numbers 21 and 32 do not appear in the final version.

Three reasons instigated the use of a consumer questionnaire:

- 1) To provide an alternative form of expression to the verbal.
- 2) To provide a greater understanding of the characteristics of the focus group and other participants (ie. age, etc).
- 3) To respond to sensitive and personal material in a confidential matter, rather than only in an open group discussion.

Cultural Translation of Consumer Questionnaire

This process of translating the questionnaires was highly interactive, and involved in some cases, several persons from a given community who spent hours being clear and concise, posing questions back and forth to each other and to the researcher to ensure concepts were consistent and no misinterpretation occurred, particularly around birth control methods.

For some communities, cultural translators made small changes from the English version of the questionnaire. The changes did not affect the standardization of the questionnaire, but made it more relevant to each of the racial and cultural communities.

(See Appendix C for English version. Other languages available on request from Planned Parenthood).

Agency Survey

The main purpose of the agency survey was to identify whether culturally and racially appropriate family planning services currently exist in Hamilton. The second purpose was to obtain suggestions on which racially and culturally diverse groups should be asked to participate in determining possible needs within their racial or cultural group.

A small number of participants were uncomfortable with the second purpose of the agency survey or felt they did not have the "hard data" or information, from their agency, on which to base their impression.

Eighty-two agency questionnaires were mailed out. Five were returned due to errors in location, or to the organization no longer operating. The total number of possible responses was 77.

Of these 82 agencies/groups, 61 were generic, 18 were ethno-specific, 2 were both and 1 was neither.

Additional measures were taken with the agency survey which ensured an unusually high return rate. Initial questionnaires were mailed or hand-delivered. Follow-up phone calls were made, and a significant percentage of questionnaires were picked up. In cases where questionnaires were misplaced, a second copy was mailed out, as requested. Any questions regarding the questionnaire were answered either by phone or in person. (See Appendix D for copy of the survey).

Pilot Focus Group

The pilot focus group was crucial to defining direction and to beginning to hear what issues (if any) racially and culturally diverse persons identify in relation to family planning. General questions were asked and several questions were asked to the researcher by the group. (See Appendix E for pilot focus group questions)

The pilot focus group consisted of 12 people, 3 male, and 9 female, approximately 66% of whom were from Central America, others having immigrated from Portugal, Romania, Italy, and Poland.

The following outlines the age range of the participants:

16-25	26-30	31-35	36-40	41-50	51-64	65+
2	3	3	2	0	2	0

This heterogeneous group was already meeting for the purpose of learning English.

Changes Made

This group made it clear what their needs were, and two important changes were made to the methodology with future focus groups:

1. It became apparent that the structured nature of the class and the time restraints imposed did not allow for great depth in the discussion.
2. The pilot confirmed the expected desire to have separate male and female groups.

Unsuccessful Attempts at Organizing Focus Groups

Mostly due to time restraints, attempts at organizing focus groups were unsuccessful in the Spanish, Arab, Native, and Cambodian communities. As anticipated, it was difficult to organize groups of men to participate in focus groups.

Focus Groups

The focus group is a reflection of the racial and cultural group in which the participants belong. The information gathered from these participants is unique, as individuals, but with a shared understanding.

The purposes of the focus groups were:

1. To listen to and understand racially and culturally diverse women's (and men's responsibility to family planning where men participated in the focus groups) past and present experiences in family planning.
2. To generate involvement from racially and culturally diverse women (and men) who may not normally have access to mainstream organizing and decision making.
3. To understand and identify cultural and religious norms, and barriers to accessing services in family planning.
4. To understand attitudes towards various methods of birth control.
5. To arrive at a group consensus on possible changes that need to be made (recommendations), and ways to go about these (implementation).

Process of Focus Groups

An agenda was used in a semi-structured format (See Appendix F). The key informant was present, a cultural interpreter (which in two of the focus groups was the same person as the key informant), the participants, and the researcher. The sessions were documented in written form by the researcher. The sessions were not taped for comfort reasons. Once all the information was recorded, a copy (in detail) was given back for group critique. Groups were asked to be critical of all the information recorded by the researcher without the researcher being present, and at their leisure. This was crucial in ensuring that there was no subtle influence or pressure by the researcher, and secondly, that the focus groups had an opportunity to examine all of what was

recorded, make changes, and provide consent in writing. Any changes made by the focus groups are included in the findings.

The focus group discussion ranged from 2.5 to 5.5 hours in length with a total of 24 hours for 7 focus groups.

Facilitators/Cultural Interpreters Chosen for Focus Group Discussions

All facilitators/cultural interpreters were from the communities which were being represented. They were, therefore, aware of the language and the culture of the group, and at times shared their own experiences, in the focus group discussions.

Locations

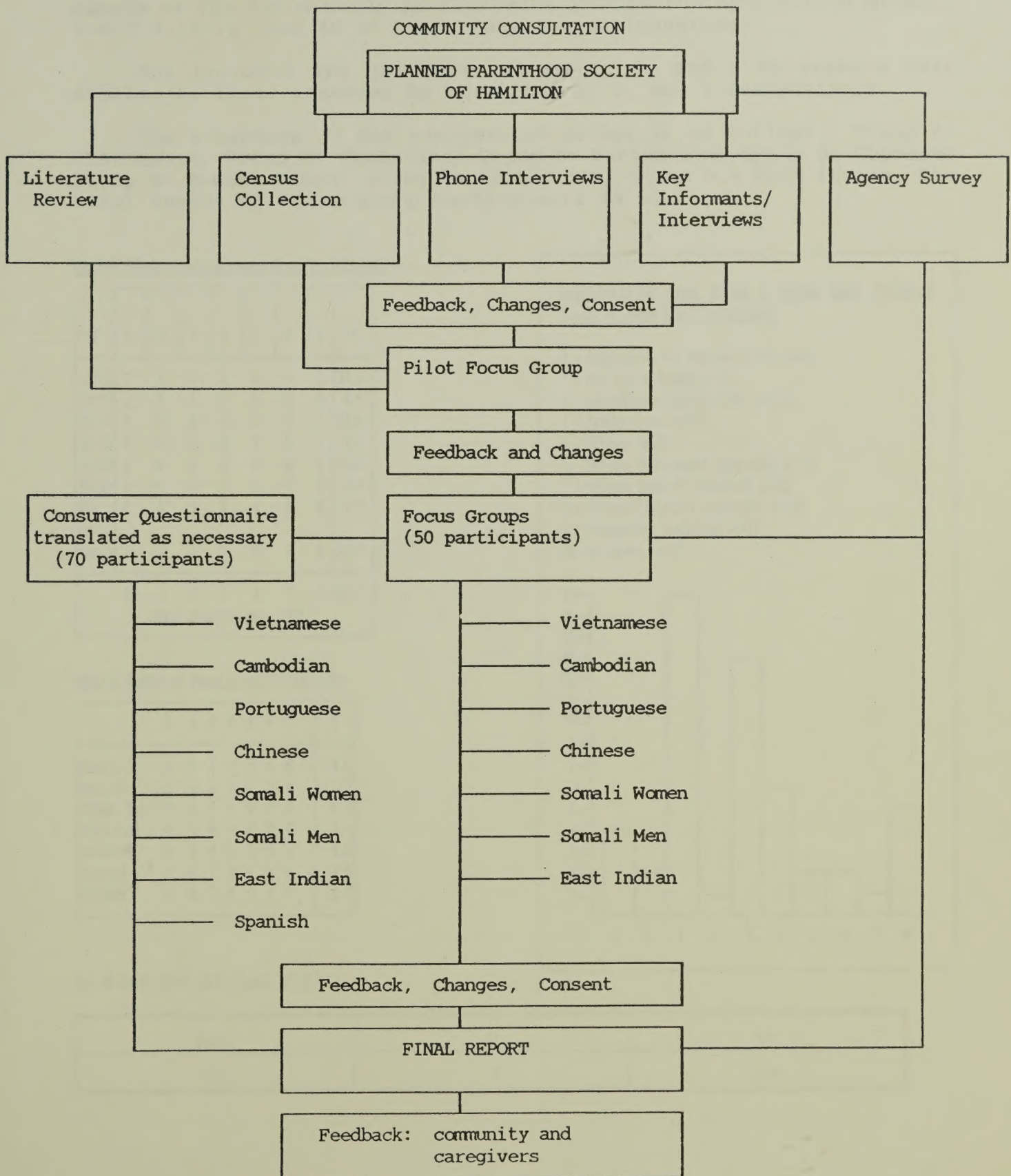
The majority of the focus groups were held at the key informant's home, either as a group at the kitchen table or as a group in the living room. Focus groups were also held at local community centres which were familiar to many of the participants.

Comparison between pilot focus group and secondary focus groups

Some important differences improved the quality of the information gathered and comfort of the participants in the focus groups:

- * groups were homogeneous ie. either all women or all men
- * there was no external structural influence ie. class setting
- * participants were freer to choose to participate ie. not connected to a class setting
- * the participants reached were often more isolated within the community hence the greater likelihood that they did not have regular access to mainstream services

SUMMARY OF METHODOLOGY:
DATA COLLECTION AND PROCESSING



FOCUS GROUPS SAMPLE

The following charts detail the personal characteristics, or sample of the focus group participants as answered by question numbers 1-4,7,9,10-18, and 40 of the consumer questionnaires.

Not included are questions number 5, 6, and 8 as answers were similar to those answered by questions 2, 3, and 7 respectively.

The breakdown of the represented groups is as follows: Group A= Vietnamese; Group B= Cambodian; Group C= Portuguese; Group D= Chinese; Group E= Somali women; Group F= Somali men; Group G = East Indian. The total number of Focus group participants is 50.

Age and Ethnic Origin of Focus Group Participants

AGE	A	B	C	D	E	F	G	%
16-25	3	1	3	1	5	3	0	32.0
26-30	1	1	0	0	0	1	0	6.0
31-35	2	0	0	3	2	3	1	22.0
36-40	0	0	1	0	1	0	2	8.0
41-50	1	0	1	1	0	0	1	8.0
51-64	0	0	2	1	0	0	0	6.0
65+	0	0	2	0	0	0	0	4.0
not known	3	1	1	0	0	2	0	14.0
10 3 10 6 8 9 4 100.0								
Total Participants (50)								

Marital Status of Focus Group Participants

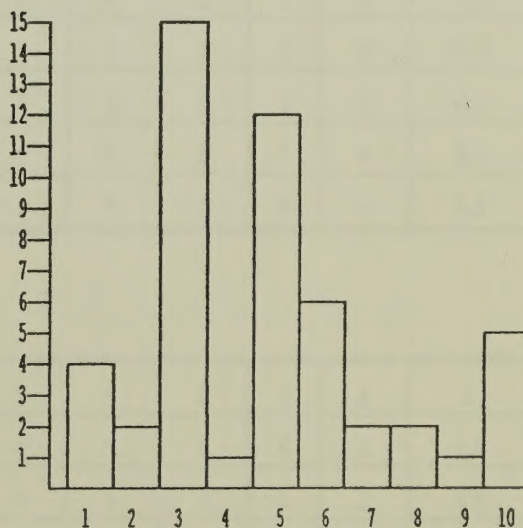
	A	B	C	D	E	F	G	%
Single	3	0	3	0	5	6	0	34.0
Married	4	3	5	6	2	1	4	50.0
Common-law	0	0	0	0	0	0	0	0.0
Separated	0	0	0	0	0	0	0	0.0
Divorced	0	0	0	0	0	0	0	0.0
Widowed	0	0	1	0	1	0	0	4.0
Unknown	3	0	1	0	0	2	0	12.0

Sex of Focus Group Participants (n=50)

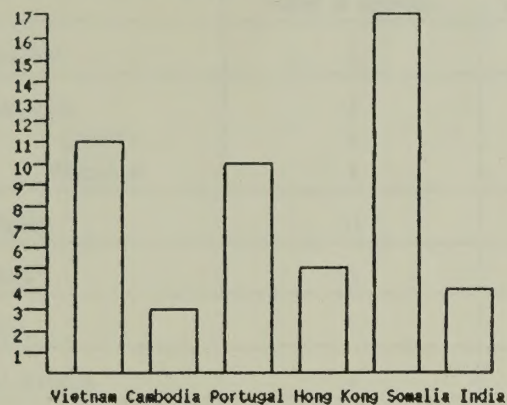
Female	41	82%
Male	9	18%

Application for Legal Status or Current Legal Status in Canada of Focus Group Participants

- 1 = Application for Refugee status (n=4)
- 2 = Minister's Permit (n=2)
- 3 = Landed/Permanent Resident (n=15)
- 4 = Family Class (n=1)
- 5 = Citizen (n=12)
- 6 = Refugee (government sponsored) (n=6)
- 7 = Refugee (church sponsored) (n=2)
- 8 = Refugee (relative sponsored) (n=2)
- 9 = Independent Immigrant (n=1)
- 10= No answer (n=5)



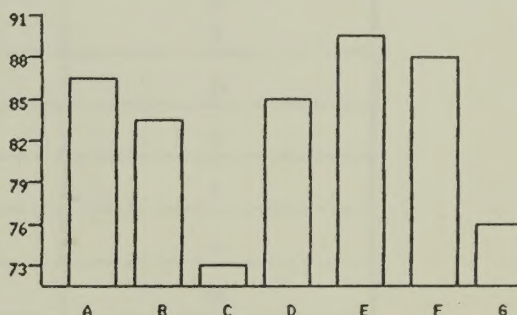
Place of Birth of Focus Group Participants



* one Chinese woman was born in Vietnam

Arrival in Canada of Focus Group Participants

A: 1979-1991 average: 1987.0
 B: 1984-1985 average: 1984.5
 C: 1960-1987 average: 1973.0
 D: 1980-1990 average: 1985.8
 E: 1989-1991 average: 1989.3
 F: 1979-1991 average: 1988.3
 G: 1972-1980 average: 1976.3



Languages Spoken by Focus Group Participant

	A	B	C	D	E	F	G	#	%
other	1	0	0	0	1	0	0	2	4.0
2 or more excluding English	0	0	0	0	0	2	0	2	4.0
2 or more including English	0	0	0	0	0	2	1	3	6.0
English* and Mother Tongue	2	1	2	3	0	1	3	12	24.0
Mother Tongue only	6	2	4	3	6	2	0	23	46.0
English only	0	0	3	0	1	0	0	4	8.0
No Answer	1	0	1	0	0	2	0	4	8.0

Languages written and read by Focus Group Participants

	A	B	C	D	E	F	G	#	%
other	1	0	0	0	1	0	0	2	4.0
2 or more excluding English	0	0	0	0	2	0	0	2	4.0
2 or more including English	0	0	0	1	1	5	1	8	16.0
English* and Mother Tongue	3	0	0	3	1	0	3	10	20.0
Mother Tongue only	4	2	5	2	3	2	0	18	36.0
English only	0	0	3	0	0	1	0	4	8.0
No Answer	2	1	2	0	0	0	0	5	8.0

* includes various degrees of English comprehension/communication

What is your religion? Are you currently practising your religion?

	Number of Responses	% of responses to total	Number practising their faith
Buddhist	6	12	5
Christian	1	2	1
Catholic	9	18	9
Protestant	4	8	3
Muslim	15	30	14
Hindu	3	6	3
Jain	1	2	1
No Religion	4	8	4
No Answer	7	14	10

How long did you live in your country of origin?

Vietnamese (n=9)	28.1 years average
Cambodian (n=2)	15.5 years average
Portuguese (n=8)	28.8 years average
Chinese (n=6)	24.3 years average
Somali Women (n=8)	21.9 years average
Somali Men (n=8)	19.0 years average
East Indian (n=4)	23.8 years average

Total Annual Income

Annual incomes	%	n=
less than \$5,000	46.7	21
\$6,000-\$9,999	6.7	3
\$10,000-\$19,999	20.0	9
\$20,000-\$29,999	11.1	5
\$30,000-\$39,999	4.4	2
over \$40,000	2.2	1
No Answer	8.9	4

Did you live in the country or the city?

	City	Country
Vietnamese (n=9)	7	2
Cambodian (n=2)	0	2
Portuguese (n=6)	4	2
Chinese (n=6)	4	2
Somali Women (n=8)	8	0
Somali Men (n=8)	8	0
East Indian (n=4)	4	0
Totals	36	8

What level of schooling did you complete?

	%	n=
Secondary (grades 9-13)	44.4	20
Elementary (grades 1-8)	26.7	12
Post Secondary	20.0	9
Unknown	8.9	4

What was your occupation before coming to Canada?

	%	n=
White collar related	38.0	17
Student	20.0	9
No answer given	15.6	7
Homemaker	13.3	6
Blue collar related	6.7	3
Not applicable	6.7	3

What is your occupation now?

	%	n=
Student	28.8	13
No Answer Given	20.0	9
Homemaker	15.5	7
White Collar related	15.5	7
Blue Collar related	13.3	6
Unemployed	6.7	3

FINDINGS

Whenever possible, direct quotes were maintained. In the case of the focus groups and all interviews, the information was summarized and approved by the participants prior to being incorporated in the findings section.

KEY INFORMANT INTERVIEWS

Several common themes emerged. General points are noted, as well as references to particular cultures or religions, which were made by key informants speaking about their own communities.

A. Information

Key informants were clear in their views regarding information on family planning and birth control for the racially and culturally diverse populations: both in its lack, in its currently inappropriate form; in its poor communication.

Lack of Information

- * There is a lack of written information available in various languages on birth control methods available in Canada, on infertility, child-rearing and disciplining etc.

"A couple did not want any more children, however information about contraception was not easily accessible in their own language."

Current Information

- * Information which is available is filled with technical language.
- * Information which is available often has racial and cultural stereotypes.

"Many women turn to Natural Family Planning, and yet, they do not have racially and culturally appropriate information on effective natural family planning methods."

- * Information which is available is presented with Western terms and values, for example emphasizing 'pushing pills' or 'pro-choice.'
- * Information which is available lacks a thorough description of the risks and benefits of all birth control methods.

Communication and Information

- * Sharing of information is difficult: clients have to indirectly bring up the issue (especially if social service, and health care workers are not sensitive or comfortable with the issue).
- * Some English words are not easily translated in some languages, hence making the potential for sharing embarrassing.
- * There is a lack of 'good' interpreters available.
- * Confidentiality on such a personal topic is a real concern, especially in a small community where people know each other.
- * Information received in one's country of origin may differ from information here.
- * Different dialects, within a culture, require the information to be accurate and specific.
- * There is misinformation about natural family planning; many women do not have enough information to make the method truly effective
- * Due to language barriers, informal community networks are established to share information about service access.
- * Women especially lack information and need it for greater equality.
- * There exists a subtle message that family planning is entirely the woman's responsibility; information is not presented encouraging equal participation, for example, men's use of the condom. Condoms tend to be outside the norm of birth control and the machismo attitude.
- * Sex education is restricted in some institutions due to religious and/or cultural beliefs.
- * Planned Parenthood Society of Hamilton is not well known amongst racially and culturally diverse communities.

"A Portuguese woman who wanted an abortion could not speak English. She brought her 12-year-old-daughter to do the translating."

"A Mexican woman got pregnant while using the birth control pill. She was taking it once a week."

B. Economics

"We can't afford any more children".

On the whole there was a common theme that family planning and birth control options were linked with economic status ie. the greater the economic resources, the greater the options available, both here and in one's country of origin.

Economics, Family Size and Family Roles

- * Men take pride in being able to provide for their families while their wives stay home and care for the children.
- * Aging parents rely on their children for economic support.
- * The socio-economic status of the couple has an impact on family size: the greater the number of children, the greater the labour and the security of economic survival (in country of origin).
- * Smaller family sizes are seen as necessary for many in Canada because of the harshness of their economic situation.

Economics and Birth Control Options and Services

- * Low income people do not have as many options open to them; the high cost of some forms of birth control means only rich women can afford them.
- * Transportation costs restrict access to birth control services.
- * Women have had induced abortions because birth control services were too costly or unavailable.
- * The welfare system does not cover all forms of birth control on recipients drug plan: right now only the birth control pill is covered free of charge; this is a Western bias towards methods and may be inappropriate for certain cultural and religious beliefs. All methods should be included.

C. Cultural and Religious Values regarding Family Planning

Generally

- * There exist strong family values which tend to be in favour of procreation.
- * Sexuality issues are often taboo and not discussed, even between partners.

* Sexuality is viewed as an "adult only" issue.

* There is diversity of beliefs within a given racial/cultural group, based also on individual's personal experiences.

* There are varying degrees of acceptance of birth control use and natural or artificial methods.

"A mother, whose teenage daughter became pregnant, could not cope with the humiliation and 'criminality' of her child's actions. She said she would have preferred her own child's death, than to have a daughter shame the entire family with an unwanted pregnancy or abortion."

* There were two perceptions of abortion: abortion is generally acceptable and is treated as a form of birth control, versus, abortion is not generally acceptable while the reality is that some women will have an abortion as a last resort.

* There tends to be shame associated with teenage pregnancies.

* Common inter-generational conflicts, combined with the children's external western influences, strain family relationships.

"A Portuguese woman who was engaged to be married had an unwanted pregnancy. She was afraid of the reaction she would receive from her community and family, who would now know she was having premarital sex. She had an abortion."

* There are stereotypes that racially and culturally diverse groups are more prone to violent behaviour, for example, in child-rearing practices.

In the Past

* Standards and morals on reproductive and sexuality issues were "higher" in the past than today, for example:

- * women were wives and mothers at home
- * premarital sex was not acceptable
- * young girls/teens were expected to be "clean" or virgins for their future mate

* Natural family planning or no planning was used

Current Beliefs

* Religious: Several key informants highlighted what they believed to be the key values of their religion in relation to family planning issues:

Protestant	the family is seen as important; not against family planning or birth control, but against pre-marital sex
Buddhism	the family is seen as important; does not state for or against birth control/family planning; boys are desired
Confucianism	big families are preferred to carry on the family name; does not state for or against family planning or birth control
Ancestral following	(individuals worship their family's name and its values and customs); does not state for or against birth control and family planning; children are wanted to carry on the family name
Muslim	the family and procreation is very important
Native spirituality	the family is seen as important; there is a belief in the moon as a guide to women's fertility; this is a spiritual guide but also a practical guide; women/girls learn to pay attention to their bodies; to become aware of changes to it; fertility; emotionally they learn about self-respect and respect for others
Catholicism	the family is seen as important; against artificial birth control methods; for natural family planning methods; against pre-marital sex

- * The family is still very important.
- * There tends to be less extended family input affecting the couple's decision on family size.
- * Many can no longer afford to maintain traditional values of having many children, while in Canada.
- * Sometimes women are feeling lonely and isolated in a new country; they long for the feeling of 'family' they once had in their country and therefore start their families sooner than they might be financially ready to.
- * Today couples want a better lifestyle for their children and find it is too much of a financial burden to have many children

D. Sexism and Family Planning

- * Men tend to be the head of the household: many men cannot adapt to women's changing role and greater rights in Canadian society.

"A couple had nine girls. They continued to have children so they could have a son. Their tenth child was a boy so they stopped having children."

- * Many men are not emotionally or financially ready for fatherhood, and they tend to leave the relationship when the woman becomes pregnant.

- * Boys are preferred; girls are accepted; boys are needed to maintain the family name.
- * Boys were needed to protect the family's property or the country in cases of war.
- * Some men believe it is their responsibility to teach women about sex and reproductive issues.
- * Men generally do not like to use the condom, due to physical discomfort and/or machismo attitudes.
- * Abusive husbands use family planning disagreements, such as family size or use of birth control, as an excuse for beating their wives.
- * The husband tended to be in a position of power and control within the family unit--making decisions, including family planning, for the whole family.

"A woman who had a job in her chosen career became pregnant. Her husband, who appeared domineering, disapproved of her having an abortion. He wanted her to be a housewife, to be at home, and have his children. The woman was afraid to have an abortion against her husband's will; she continued with the pregnancy but was not happy."

E. Systemic Oppression

- * A barrier in accessing family planning services is established for women who have had experience with oppressive population control programs in their country of origin--for example, when options are removed through financial incentives or disincentives, such as providing food or invoking tax increases after a certain number of children.
- * There is confusion between Canada's immigration policy of acceptance for immigrants and refugees, yet its lack of openness in terms of accessing resources, and having equal education and employment opportunities.
- * The media can further oppress by stereotyping, emphasizing myths, generalizations, and blaming society's ills on the racially and culturally diverse.
- * The system here tends to target white, middle-class consumers as opposed to systems in other countries, where services are holistic and community-based inviting participation and family involvement, both in attitude and in structure.
- * There is a need for more racially and culturally diverse health and social service professionals in Hamilton ie. there are few Spanish-speaking, and no Cambodian or Vietnamese-speaking doctors in Hamilton.

- * The skills of immigrants or refugees are often not recognized in Canada, limiting economic opportunity and therefore accessibility to services.
- * Many (60-70%) of persons applying for refugee status in Canada are not covered under OHIP, often having to wait long periods of time, hence putting their health at risk.
- * Refugees who must deal with their past experiences of rape, torture, and repeated abuse find a Canadian health care system, which is not sure how to respond to this.

F. Settlement Issues and Family Planning

- * One's fertility and the timing of having children is affected by the stress of settling in a new country and dealing with all the changes.

"I am a Spanish woman having immigrated from Latin America. It was a hard life to settle in Canada, because of a lot of settlement issues, like finding work, learning the language, housing, and all the legal issues which is part of adjusting to Canadian society. Because of all the stress I had that went along with my settlement and trying to survive, I decided to wait until starting a family. I got pregnant, but had a miscarriage because I was still under so much pressure of adjusting to a new country. The stress did not end right away and I tried to have children but that is why I could not. Then I reached menopause, and I never had any children. This reality happens to a lot of women."

Statistics by Key Informant

Therapeutic abortion statistics are incorporated here as a measure of unwanted pregnancies. Generally, statistics are not broken down by ethnic origin. However, a key informant in the Hamilton-Wentworth region was able to provide comparative figures of abortions performed, for May and June 1991, by their service. "Multicultural" is defined as "immigrant women from countries other than North America and Britain".

Date:	Abortion: Total Population	Abortion: Multi- cultural	% Multicultural to Total Population
May 1991	86	17	19.8
June 1991	70	15	21.4

While assuming that abortion is not a preferred method of dealing with an unwanted pregnancy (both for white as well as racially and culturally diverse women), these findings beg the questions as to whether preventative measures were used and failed or whether preventative measures were not used and would have been desired.

Consumer Questionnaire

The findings of the consumer questionnaire successfully reflect the criteria for which it was established (see pg. 20) for the focus group participants (n=50) and the Spanish community (n=25). This group appeared to prefer to respond by questionnaire only, rather than participate in a focus group.

Limitations of the questionnaire arose in attempting to gather additional information on the preferred type of service. Question numbers 25, 26, 37, 38, and 39 were not presented in an effective format to allow the participants to provide information that clearly represented their views.

Questions 28 to 36, concerning issues of accessing the system, overlap with discussions from the focus groups. Because the focus group discussions on this topic more thoroughly represent the thoughts and experiences of the racially and culturally diverse participants, these questions are best answered as part of the focus group findings and therefore have not been included in this section. However, because the Spanish community preferred to respond by questionnaire only, their responses to questions 28 to 36 are included in this section.

Included in these findings are the demographics for the Spanish community only. This information for the focus group participants is reported in the focus group sample (pgs. 25-28). With the exception of the above-mentioned questions, all findings from the Spanish community are presented in this section. Information about family size and birth control practices and experience are included for the focus group participants.

Focus Group Participants

Family Size (Questions 19 & 20)

On average the participants said they have 1.64 children, based on 44 numerical responses and 6 unanswered.

On average the participants said they want to have 3.16 children, based on 36 numerical responses and 5 unanswered. Two indicated it was not up to them to decide by responding: "Whatever God gives me".

Birth Control practices (Questions 22, 23, 24 & 27)

	In Country of Origin:	What method were you using?	In Canada:	What Method?
YES	30% (n=15)	1 condom 1 sterilization 1 withdrawal 2 natural 2 pill 8 no answer	42% (n=21)	4 condom 6 sterilization 1 withdrawal 1 condom & withdrawal 4 natural 3 pill 2 IUD
				REASON FOR CHOICE
NO	58% (n=29)	not applicable	44% (n=22)	1 not sexually active 1 against religion & not sexually active 1 too hard to use 2 want children 12 against religion 5 no answer
NO ANSWER	12% (n=6)		14% (n=7)	

Spanish Participants

Gender

There were 25 Spanish consumer questionnaires which were completed, 57.7% (n=15) by females, and 28.0% (n=7) by males with 3 unanswered.

Ethnic Origin and Place of Birth (Questions 1, 2, 3 & 4)

All participants identified their ethnic origin as Spanish, having been born in El Salvador 68.0% (n=17); Guatemala 16.0% (n=4); Nicaragua 8.0% (n=2); Honduras 4.0% (n=1); and Mexico 4.0% (n=1) and living there from 18 to 47 years, with an average of 29.8 years.

The majority of participants lived in the city, 72.0% (n=18) while 20.0% (n=5) lived in the country with 8% (n=2) unknowns.

Route of Entry to Canada (Questions 5, 6, 7 & 8)

For some participants, their route of entry into Canada has been via other countries: 24.0% (n=6) through the U.S.A., and 16.0% (n=4) through other Spanish countries, 20.0% being there for more than a year, and 20.0% being there for less than a year, while the remaining 60.0% (n=15) came directly to Canada from Latin America.

All participants stated that they came both to Hamilton and Canada between 1985-1991, the average arrival being 1989.0.

Languages spoken and written (Questions 9 & 10)

At this time, 96.0% (n=24) speak, read and write Spanish only, while 4.0% (n=1) could read, write and speak Spanish and English.

Age and Marital Status (Questions 11 & 14)

The following charts outline the age range and marital status of the participant:

What is your age range?

16-25	26-30	31-35	36-40	41-50	51-64	65+
4	7	4	6	3	1	0
16%	28%	16%	24%	12%	4%	0

What is your marital status?

Single	Married	Common-law	Separated	Divorced	Widowed
2	14	6	2	1	0
8%	56%	24%	8%	4%	0

Religion (Question 12 & 13)

Of this sampled group, 92% (n=23) identified themselves as Christian and 68% (n=17) of this same group said that they in fact practised their faith.

Application for Refugee Status or Current Legal Status (Question 40)

The current status in Canada for the participants is as follows: 36% (n=9) are currently applying for refugee status, 32% (n=8) had landed immigrants; 16% (n=4) had a Ministers permit, 4% (n=1) were refugees sponsored by the government, 4% (n=1) had family class status, 4% (n=1) had obtained citizenship and one unknown.

Education, Occupation and Income (Questions 15, 16, 17, & 18)

There were 24% (n=6) having had post-secondary education, 48% (n=12) indicated having secondary education (grades 7-12), and 24% (n=6) indicating elementary education (grades 1-6).

An important difference was in the occupational status of the participants between their country of origin and here. Sixty-four percent (n=16) were employed in white and blue collar jobs, 20% (n=5) were students, 8% (n=2) were housewives and 4% (n=1) had a farm, with one unknown. By comparison in Canada, 64% (n=16) are currently students or housewives or both, 16% (n=4) are unemployed, and 12% (n=3) are in labour, 4% (n=1) are practising their profession, with one unknown.

Reflected in this are the incomes: 52% (n=13) indicated annual incomes between \$10-19,999; 32% (n=8) indicated less than \$9,000 with 12% (n=3) being over \$20,000 and 5 unknowns.

Family Size (Questions 19 & 20)

On average the participants said they have 2.26 children, based on 23 numerical responses and 2 unanswered.

On average the participants said they would like to have 2.86 children, base on 15 numerical responses and 8 unanswered. Two said they had not decided how many children they would like to have.

Birth Control Practices (Questions 22, 23, 24, & 27)

	In Country of Origin:	What method were you using?	In Canada:	What Method?
YES	36% (n=9)	1 rhythm 1 IUD 2 condom 2 pill 3 sterilization	52% (n=13)	1 natural 2 IUD 3 condom 2 pill 5 sterilization
NO	52% (n=13)	not applicable	32% (n=8)	REASON FOR CHOICE: 1 pregnant 1 don't know where to get 1 not sexually active 1 want children 3 against religion 1 no answer
NO ANSWER	12% (n=3)		16%(n=4)	

Access to Services (Questions 28, 29, 30, 31, 31b, 33, 34, 35, 36)

With regard to the participants' ability to access the system, 96% (n=24) said that they had a doctor whom they could easily call, yet 52% (n=13) said that their doctor did not speak their language. Sixty-eight percent (n=22) said that they do understand their doctor when she or he speaks to them, and 80% (n=20) felt that they would be comfortable to ask their doctor about birth control. Of those who were not comfortable, one cited the reason as being because her husband was not currently in Canada. Ninety-five percent (n=24) of the participants spoke their mother tongue only.

Furthermore, 96% (n=24) said they know where to access interpreters and 88% (n=22) said that they have used their services at least once before. However, half of the respondents, or 44% (n=11), said they would need an interpreter when seeking help for

family planning services. More specifically, only 56% (n=14) said that they would in fact feel comfortable using an interpreter to talk about family planning issues.

Agency Survey

The findings of the agency survey are listed below. Responses to questions number 5 and 6 are not included because the answers were unclear. Also, not included is question number 13, as its purpose was to assist community organizers of the focus groups.

82 agency questionnaires were initially distributed. Of the possible total of returns (77), 72.7% or n=56 of agency's responded. The following breakdown of the agencies which responded applies:

AGENCIES WHICH RESPONDED:		Need for more racially and culturally appropriate information about family planning:
Returned: Complete (n=35)	31 Generic 1 Ethno-specific 2 Both 1 Neither	71% YES (n=25) 3% NO (n=1) 26% NO ANSWER (n=9)
Returned: Partially Complete (n=5)	5 Generic 0 Ethno-specific 0 Both 0 Neither	YES NO 100% UNSURE (n=5)
Responded: Did not complete because of conflict with agency policy, mandate and/or philosophy (n=10)	6 Generic 2 Ethno-specific 0 Both 0 Neither	YES NO 100% NO ANSWER (n=10)
Responded: Unable to complete due to time, resources, or preferred personal interview format (n=6)	4 Generic 2 Ethno-specific 0 Both 0 Neither	YES NO 100% NO ANSWER (n=6)
Total agency response: 72.7% (n=56)		
No Response		
Never Heard from/ unable to contact	27.3% (n=21)	

Does your agency serve racially and/or culturally diverse persons?

Of these 56 agencies which responded, 71.4% (n=40) said they provided services to racially and culturally diverse groups, primarily in a counselling capacity 70.0% (n=28) in the areas of employment, settlement, pregnancy, family/marital problems, psychiatry, conflicts with the law, sexual violence, life skills. This was followed by educational services, including English as a Second Language 20.0% (n=8); referrals 17.5% (n=7); medical/general physical care 15.0% (n=6); housing 15.0% (n=6); and advocacy 12.5% (n=5). Often, more than one answer was given.

Does your agency serve racially and/or culturally diverse women regarding reproduction/family planning?

The number of agencies serving racially and culturally diverse women regarding family planning services dropped considerably when asked:

Did not provide service	48.2% (n=26)
Did provide service	31.5% (n=17)
No answer given	20.4% (n=11)

What service does your agency provide to racially and/or culturally diverse women regarding reproduction/family planning?

76.5% (n=13)	information on accessing health services for women, eg. a clinic
64.7% (n=11)	concerns regarding child rearing
58.8% (n=10)	information/options regarding an unwanted pregnancy
52.9% (n=9)	provided with information on birth control methods
52.9% (n=9)	concerns regarding infertility
52.9% (n=9)	assistance regarding diagnosis/treatment of sexually transmitted diseases
47.1% (n=8)	assistance regarding their social and economic circumstances in relation to sexuality and reproductive life
47.1% (n=8)	assistance regarding conflicts in relation to their cultural and religious background and social norms in the areas of abortion, fertility, new reproductive technologies

At times, more than one answer was given.

Listed below are the groups, listed in order of mention (from most to least often), by agency personnel to be involved in the process of determining their communities' needs:

1. Spanish
2. Vietnamese
3. Portuguese, East Indian, Somali
4. Native, Chinese, Polish, Italian
5. Arab, those persons from various African countries

Please comment on any significant beliefs/values regarding your identified ethnic groups and family planning.

Agencies responded to this question, based on an impression or substantiated by the actual experiences of those completing the questionnaire. Everything is recorded verbatim:

Cultural/Religious Values

- * religious teachings are pro-natalist-children are a gift from God
- * the belief that certain methods of birth control create abnormality in babies ie. the IUD
- * religious/cultural teachings which are against birth control/abortion
- * child-centred value system which encourages large families
- * don't feel comfortable to speak about sex
- * Vietnamese traditions which are rigid; women do not have a say in family size
- * children are very important
- * if don't have children the couple is looked at as selfish; they are pitied; everyone wants children in the Spanish community

Systems Related

- * belief by immigrant women, who are not citizens that their status is in jeopardy if they require their partner to participate in family planning
- * Spanish are more used to a holistic medical approach ie. psychological/emotional and physical care is more integrated

Sexism

- * male domination in marital relationship; wife should serve husband

Economics

- * some want more children but can't afford them

List any barriers you feel exist for your identified ethnic groups, in their ability to access information or receive assistance from programs, organizations, medical services etc. regarding family planning.

Agencies identified barriers to accessing family planning services for racially and culturally diverse groups as follows:

Language

- * many of this group have difficulty accessing services due to language barriers: English speaking people are often unaware of the resources in the community, therefore I expect those lacking in English skills would find it even more difficult
- * services are not available in people's own languages
- * lack of information regarding services like Planned Parenthood
- * there is a general awareness of birth control methods, however, there are still myths/misconceptions; there is especially less information about the risks and benefits of birth control which is available

Systemic Discrimination

- * services are not always available in Hamilton-Wentworth; many clients go out of town for services
- * sensitive cultural interpreter are not readily available
- * medical system's terminology
- * systemic barriers: refugees are treated badly

- * red tape: their experiences with help agencies have been poor
- * intimidation by bureaucracy
- * racism

Economics

- * identified by all respondents, but without any elaboration

Cultural and Religious Norms

- * cultural male role differences, considered a female responsibility
- * tight community
- * the acceptance of traditional beliefs
- * different cultural norms
- * isolation

Sexism

- * general sense that men have more control over women's choices regarding family planning; traditional views of women's role in sexual relationships

Individual Issue

- * people's own beliefs/values
- * shyness and lack of assertiveness
- * poor self-esteem
- * fear of using unknown resources; suspicion of mainstream culture; how the information will be used, at times from previous experiences
- * fear of blood tests

Where do you think individuals within your identified groups would go/do go for assistance in the community to address their concerns and obtain information regarding family planning?

Currently, several agencies identified that groups do or would go for service regarding family planning to their:

- * informal community networks: family/friends
- * sources within their cultural group: other women
- * family doctor, if they have one or if he/she speaks their language
- * North Hamilton community Health Centre
- * Church/sponsor
- * School/English as a Second Language
- * Social worker
- * Ontario Welcome House
- * Multicultural Centre
- * Planned Parenthood

Do you feel there is a need for racially and culturally diverse women to have greater access to and information on reproductive/family planning services, (ie. counselling, educational sessions, medical examinations, contraceptive devices) in the Hamilton community?

Yes	71.0% (n=25)	There is a need for greater access to and information on reproductive/family planning issues for Hamilton's racially and culturally diverse groups.
No	3.0% (n=1)	There is currently sufficient information and services.
Unknown	26% (n=9)	No answer given.

Why or why not?

Several reasons were cited as to their being a need:

1. "Hamilton is a multicultural community and should recognize different needs of people from diverse cultural backgrounds."
2. "Sexuality is intensely personal and therefore very much tied to cultural values and beliefs. Information must be available in culturally appropriate ways."
3. "Because the sources available to them might not be as effective as professional family planning services."
4. "T.V. and the media destroys good morals; adultery, affairs, rape, murder, vengeance is accepted."
5. "Many women are struggling against poverty for a variety of reasons and would like to have access to birth control means."
6. "Better methods of communicating what is available to them. Accepting cultural differences and traditions. Adapting programs so they are accessible to all groups."
7. "No information/very little exists."
8. "Male domination."

What do you believe would be the most effective way of meeting the needs for your identified group?

Common responses included providing information and assisting in accessing the system through:

* Education

- * information in their own languages
- * information on birth control methods
- * community leadership involvement
- * conduct groups
- * develop pamphlets; also on how to access the system
- * English as a Second Language classes
- * speakers from the various communities
- * grant religious permission
- * include Sexually Transmitted Diseases/AIDS topics
- * work with counsellors in the mental health field

* Services

- * services in their own language
- * alternatives such as home visits
- * counselling
- * support during pregnancy/parenting
- * trained professional interpreters

Is there any additional information or suggestions which might help Planned Parenthood's ability to meet the needs of Hamilton's diverse racial and cultural communities?

The agencies recommended that Planned Parenthood should meet the needs of various racially and culturally diverse groups by:

- * meeting with and asking the identified groups and community leaders about this issue;
- * not assuming that people want to participate in family planning;
- * ensuring written material is available which is culturally appropriate;
- * providing culturally appropriate services including cultural/language interpretation;
- * encouraging religious/cultural permission in sexuality issues;
- * developing pamphlets to increase accessibility to service;
- * providing alternatives such as home visits, group work;
- * introducing birth control methods available in Canada in English as a Second Language classes;
- * working with counsellors in the mental health field;
- * working towards a 'hands on' personal approach;
- * educating men as well as women;
- * liaison with other ethno-specific services such as Immigrant Serving Interagency Network; Cultural Interpreters Advisory Committee; Ontario Welcome House; Multicultural Centre; English as a Second Language Courses.

Pilot Focus Group Highlights

The male and female pilot focus group made it clear that while there was a general familiarity with various methods of birth control in their country of origin, the participants were not certain if the same methods were available in Canada. In fact, the same methods are available in Canada, with the exception of Depo-Provera and slightly different forms of the IUD.

Further discussion revealed a "common" practice of women, in their country of origins who would have 10 or 11 children, and then seek birth control assistance, because or in spite of religious, cultural, access, economic, and/or health reasons.

The group was polarized when asked "If your good friend tells you that her husband wants to have more children but she does not want to, what would you say to your friend? How would you help her?" presenting two distinct views:

1. "the woman should read the bible, have the children, and uphold the Christian values"
- and
2. "she should get her husband to a centre and get assistance so that the decision could be made together".

The group also discussed the difference in service delivery. For example, in Latin America a worker usually goes to individual homes and provides information in a more personal way, at times working with the entire family on family planning. This was considered effective.

This group stated that they would like to be better able to access services and felt there was a need for greater sensitivity towards racially and culturally diverse groups, by caregivers.

FOCUS GROUP FINDINGS

To avoid generalizations and hence stereotypes, each focus group discussion has been reviewed and approved by the groups. The following information and experiences have been condensed from the approved version, for space considerations. The full version is available at the Planned Parenthood office for reference.

The same codes apply to each of the focus groups as were identified in the sample.

General Concerns of Groups

- * family planning is defined in Western terms
- * family planning is against the religious belief of having many children
- * artificial birth control is against certain religions
- * sexuality education may be interpreted by a teen as encouragement to become sexually involved
- * whether the information will actually be viewed and acted on, and not be "shelved"

Explain Birth Control and Family Planning in Your Country of Origin and in Canada

A: Vietnamese Focus Group

In the past in Vietnam:

- * natural family planning or no planning occurred in the past in Vietnam

Currently in Vietnam:

- * there is a difference in family planning and birth control between North and South Vietnam:

North:

- * under the communist government the law (since 1975) is that you can only have 2 children
- * birth control is available: the pill, IUD, condom
- * the IUD and the condom is the most common and most affordable
- * the pill is available but difficult to get and expensive; it is generally not liked because it is "a chemical" and can have side effects

South:

- * individuals have more choice
- * most kinds of birth control methods are available, except the diaphragm
- * some prefer natural family planning
- * the IUD and the condom are the MOST common methods used

B: Cambodian Focus Group

In Cambodia:

- * birth control is not known about in Cambodia, generally speaking except in refugee camps where it is encouraged

In Canada:

- * 2 of 3 women stated that when they came to Canada they did not know about birth control or family planning; upon arrival, they talked with friends (previous Cambodian settlers) who advised them to talk to a doctor

C: Portuguese Focus Group

In Portugal:

- * 15-30 years ago in Portugal, "nothing was available"; in general, no planning of children took place
- * sexuality/reproduction was not talked about
- * before 1975: life was restrictive and oppressive in all aspects

Currently in Portugal:

- * there is a democratic government in power: birth control and abortion are available in Portugal although not approved by the church or the culture; sexual activity is acceptable only within the context of marriage
- * a clinic was formed: the clinic deals with family planning/birth control, and various health concerns

Currently in Canada:

- * the Catholic church is still central to the beliefs of the Portuguese
- * artificial birth control is not approved; only natural family planning
- * sexual activity is acceptable only within the context of marriage

D: Chinese Focus Group

In China:

- * about 40 years ago, China had little or nothing to do with family planning or birth control
- * there was no direct service available
- * couples were having 'large' families
- * low-income families were having more children because they were not familiar with various methods
- * husbands were not concerned about women having more children; men did not believe in birth control
- * there were many unwanted pregnancies: women would induce a miscarriage
- * there were many illegal abortions performed
- * any services which were later available were hard to access
- * gradually, the government began to encourage family planning and birth control to the general population

Currently in China:

Mainland China:

- * in mainland China couples are allowed 1 child only for 'full allowance' (the equivalent of the baby bonus here)
- * if couples have 2 or more children no allowance will be granted to those individuals
- * because of this restriction, if a couple has a baby-girl, she may be abandoned with the intent to conceive a son

Hong Kong:

- * there now exists a Family Planning Association in Hong Kong
- * couples are encouraged to contact this organization prior to marriage
- * many seek the advice of doctors re: family planning and birth control
- * there is much education on birth control and family planning

In Canada:

- * in general, Chinese families are having fewer children: 2-3 children is an average while 4 is the exception

E: Somali Women's Focus Group

In Somalia:

- * most women, in the past, would not plan; women would have children until they could no longer have them; 9 children was not uncommon
- * some would use natural family planning (rhythm method) and/or withdrawal
- * the Muslim faith teaches that children are a gift from God and one does not have to worry because God will provide for the children
- * the younger members of the group (1/3 of the group) stated that they were not in support of these beliefs or methods
- * many 'educated' women, who wanted birth control, could not access birth control services and did not know how to meet their needs
- * in the last 5 years in Somalia, community programs regarding family planning have been established emphasizing the problems that can occur with large families, and close, unwanted pregnancies;

In Canada:

- * some members of the group believed that many Somali women living in Canada have similar beliefs/views as they held in their country of origin
- * women are put in the position of deciding between the teachings of their religion, which encourages many children, and their personal preference to have fewer children
- * four women in the group stated that given this conflict they would prefer to follow their faith and not feel guilty
- * four other women in the group believed that many Somali women would be willing to seek birth control/family planning services, but they do not know where to go for it; those women feel assured that they would be doing the right thing because of practical reasons (eg. their financial situation)

F: Somali Men's Focus Group

In Somalia:

- * some members in the group believe that the whole philosophy of Planned Parenthood is against the fundamental faith of Muslim regarding procreation--with the exception of individuals who need to be treated for sexually transmitted diseases
- * unlike in other countries, in Somalia there is no concern about limiting the number of children or preventing pregnancy, and many follow this view
- * issues of sexuality/birth control/family planning are taboo

- * programs have been organized by the government in the more recent years
- * sometimes these programs are offensive to those who practice the Muslim faith; people who use family planning and birth control services, are thought badly of
- * other members in the group believed that there are a lot more Somali people who are having sex but don't admit it, for example, "there is more than we think: there are nightclubs, dances that people go to, where they meet new people and eventually may be having sex"

G: East Indian Focus Group

In India:

- * over 20 years ago, there was no family planning; 8-10 children was average
- * one woman gave an example of a woman who had 13 children, but only 3 survived due to poor medical help
- * in general, people did not talk about sexuality/family planning issues
- * about 20 years ago, family planning centres were formed in India, mainly in the city encouraging the use of birth control
- * the government used to pay people to use birth control, including sterilization
- * 10 years ago, Sanjay Gandhi required all men between the ages of 25-35 to have a vasectomy
- * condoms became known through advertisements; condoms were commonly used because they were free or less expensive than the pill
- * the government encouraged 2-3 children but there was no punishment imposed if couples had more than 2-3 children
- * generally, couples did not use the pill because it was expensive and not acceptable because of potential and actual side effects
- * about 12 years ago in India, most methods were available except for foams, jellies, and the diaphragm; one woman (having worked on this issue in India) said that in fact all methods were available but the condom was encouraged because it was cheapest and there were no side effects

Currently in India:

- * even today there is not the openness about sexuality, reproduction, and family planning issues in India as there is in Canada
- * one woman stated that many women get their tubes tied after having their children

Urban Versus Rural Influences in Birth Control Use and Access to Services

In general, participants said that those individuals who wanted to use family planning methods had an easier time accessing services in urban areas.

A: Vietnamese Focus Group

- * most people in the city have greater access: all methods are available
- * in the country there are less options: not all methods are available and a lot of people use natural family planning

B: Cambodian Focus Group

- * in the city there were many home births, but better accessibility to birth control and family planning services
- * in the country people were poor, and they had difficulty accessing doctors, and a fee for the doctor's services was required

C: Portuguese Focus Group

- * there was not much difference between the city and the rural areas in the past in accessing family planning services since none existed and no family planning took place
- * neighbours/friends/midwives would help one another: there were many home births especially in the country where access to services, doctors, was very difficult

D: Chinese Focus Group

- * birth control and family planning services were easier to access in the city, and much harder to access in the country

E: Somali Women's Focus Group

Urban:

- * individuals tended to be less influenced by religious teachings; to do more what they wanted to; to have more knowledge of and access to resources like birth control services
- * generally speaking, individuals would practise birth control and family planning in the city more than if they lived in the country

Rural:

- * individuals tended to follow their religious beliefs more strictly; were not likely to practise family planning; and did not have knowledge or access to resources like birth control services
- * also in the country, children are necessary for the family's economic survival

F: Somali Men's Focus Group

Urban:

- * people tended to be more educated, know about family planning, and to use birth control

Rural:

- * there is less use of birth control methods and concern for family planning
- * people tend to use natural family planning over artificial birth control
- * sometimes, farmers or settlers from the country go to the city to get birth control
- * the Nomads, which make up about 65% of the population relocate and would have access to resources through their family
- * small villages near cities, are often more influenced by the city lifestyle and resources and hence would have greater access to birth control services

G: East Indian Focus Group

Urban:

- * family planning centres were located in the cities
- * the various methods of birth control became more accessible and available to couples: the pill, the IUD, the condom
- * transportation was available making it easier to access these centres

Rural:

- * the people in the country have "more enjoyment of children"
- * transportation is difficult (bicycles and bullcarts are used, and there are many unpaved roads) to get to family planning centres
- * there might be occasional government outreach to the small villages

Economics and Family Planning

A: Vietnamese Focus Group

- * the group agreed that money was important in deciding the number of children, eg. if no money, or little money, people should have less children
- * this was also seen as Western influence

B: Cambodian Focus Group

- * there was exchange of birth control for food in the refugee camps

C: Portuguese Focus Group

- * 3 views arose: financial restraints do determine family size ie. the less the finances the fewer number of children
- * it is important to have money to raise 'many' children but it is not a final determinant in family size
- * money is not the primary determinant in family size

D: Chinese Focus Group

- * economics is not the main influence in determining the number of children but rather the educational level of the couple
- * in the past: poorer families, who had less education would have more children because many did not know about birth control and because children were needed for assistance with the labour of the household
- * this compares with a few higher income families who were not having many children

Currently in China:

- * 2 views arose: richer people are afraid to have more children today
- * working professionals have little time to look after the children

E: Somali Women Focus Group

- * in the past, this was not a concern, because God would provide for children
- * today, some couples won't have as many children because of financial difficulties

F: Somali Men's Focus Group

- * children are also valued for economic reasons in Somalia since they provide assistance in farming which in turn improves production

G: East Indian Focus Group

- * 2 views arose: the couple's decision would not be based on their financial status
- * the couple decides to wait until they were more socially stable after their settlement in Canada

Identification of Cultural and Religious Influences

What your faith tells you in relation to birth control and family planning:

Buddhist	-no rules exist against birth control use: artificial or natural birth control methods
Catholic	-against artificial birth control; in favour of natural family planning
Protestant*	-not against birth control use
Muslim	-generally encourages children and discourages birth control use; natural methods are more acceptable than artificial methods
Hindu	-children are encouraged; modern methods are accepted

* representative of those sampled, and not all Protestant denominations

Whose responsibility is it to plan the number of children?

	Ideal:	Actual:
Vietnamese	-both a man's and woman's responsibility	-both the man's and woman's responsibility
Cambodian	-both a man's and woman's responsibility	-both the man's and woman's responsibility
Portuguese	Two views: -a child is a gift from God -it is a shared responsibility	-it is outside the couple's hands except if it is natural family planning -it is a shared responsibility
Chinese	-both a man's and woman's responsibility -the man should use a condom	-often tends to be the woman's responsibility
Somali Women	-both a man's and woman's responsibility	-numbers of children are determined by the husband however, an educated woman is also involved in the decision
Somali Men	-both a man's and woman's responsibility	-men don't generally like the condom
East Indian	-a shared responsibility	-in the past, the man had the final say; (men would say it is the woman's role); -the responsibility still tends to fall on the women

A: Vietnamese Focus Group

Purpose of Children

- * children are seen as central to the happiness of the family
- * for fulfilling Gods' will
- * to contribute to the family and society
- * to carry on the family's name
- * to take care of the elders

Sex of the Children

- * the sex of the children is important: 'a family must have a boy'
- * sometimes the sex of the child determined family size: the couple keeps trying to conceive a son

Family Size

- * in the past, 'more' children were preferred: 6-7 children was an average; today, 'less' children are preferred: 2-4 children is average
- * couples want to feel financially comfortable before having children or having 'many' children

Family Roles

In Vietnam

- * traditional gender roles existed: the man was responsible to financially support the family while the woman was to be a housewife

In Canada

- * it is different here: often, both the man and the woman must work for economic survival, hence, the couple shares the family roles more

Marital Status and Sexuality / Reproduction

- * pre-marital sex is not approved: "girls try to stay clean for their husbands"
- * some prearranged marriages
- * married women learn about sexuality/sex within the context of marriage
- * separated and divorced women may be sexually active today because of Western influence

B: Cambodian Focus Group

Purpose of Children

- * children help with the family's labour while contributing to the family's economic status and survival

Sex of the Children

- * the women stated that it did not matter what the sexes of the children were

Family Size

- * it was stated that generally it is not good to have 'many' children since many Cambodians are poor, however, at times, there are few options, or no choice
- * one woman stated that she does not want many children: 3-4; this was seen as an average by the other members

Family Roles

In Cambodia:

- * women care for the children, go to the market, and look after the household
- * men tend to work and financially support the family
- * day care is a problem in Cambodia; there is no universal day care and only the rich can hire someone to assist

In Canada:

- * women care for the children and the men work to financially support the family
- * day care is too expensive or difficult to get; the husband and wife share in the responsibility of family life

C: Portuguese Focus Group

Purpose of Children

- * children are valued, bring joy to the parents, and provide hope for the future: "a couple who does not have children, is a sad couple"

Sex of the Children

- * boys are preferred because they carry the family name although girls are acceptable
- * one woman said that it doesn't matter if it is a boy or a girl

Family Size

- * in the past 6 children was an average; today, an average is between 2-4
- * financial restraints determine family size

Family Roles

- * in the past, women stayed at home and raised the children, "he gave her a child"; today, women's roles are changing as more women are working
- * men are still the financial supporters
- * generally, the group noted that it was a minority of men who assisted in what is known as the traditional women's roles and responsibilities, today
- * three younger women stated that it should be 50-50 in finances and in household responsibilities
- * one teen in the group said she did not feel comfortable to talk to her mother about birth control and sexuality; another teen in the group said that she felt somewhat comfortable to discuss these issues with her mother

Marital Status and Sexuality

- * pre-marital sex is not accepted
- * there are more single mothers today: "people aren't waiting to get married to have children"

D: Chinese Focus Group

Purpose of Children

- * the purpose of having children is to continue the family's name

Sex of the Children

- * generally, boys were preferred in the past because of the importance to continue the family name

- * however, today, girls' status has improved in the Chinese population because of the improvement in the female status: women have more rights and improved economic status--women can get good jobs due to their better education
- * today: boys and girls are important and valued by the Chinese

Family Size

- * in the past 6-7 children was an average; today, (in Canada) 2-3 is an average and 4 is the exception
- * family size decisions are left up to the couple today

Family Roles

- * there is not as much influence by the extended family today as there once was
- * family roles were more traditional; women were expected to look after the house and the children while the man's role was to financially provide for the children
- * today there are more options for the women ie. to work or stay at home and sometimes both

Marital Status and Sexuality / Reproduction

- * premarital sex is not approved by the culture both in mainland China and here by the Chinese community, although the reality is that individuals are having pre-marital sex
- * overall, men are less criticized than are the women for having pre-marital sex

E: Somali Women's Focus Group

Purpose of Children

- * children are valued because they take care of the parents when they age
- * there is more love and closeness between the couple when they have children
- * to grow and get a better education than their parents ie. to progress
- * they can continue the family name from generation to generation
- * children are a gift from God: the more within the family, the more people to love and respect

Sex of the Children

- * many Somalis prefer boys because they can continue the family name, for example, fathers want a boy; they tend to be happier when they have a boy
- * one woman in the group said she prefers a girl

Family Size

In Somalia:

- * in the past, 10 children was an average ; today 6 children is an average

In Canada:

- * some families have 6 children on average, all of which have immigrated here; the mothers are often separated from their partner
- * the younger members of the group stated they would have 3 or 4 children, and they believed that this was average among their age group/generation

Family Roles

In Somalia:

- * the father is the head of the family and provides for the family, financially while assisting with household responsibilities such as cooking
- * the mother was responsible for taking care of the children and the home; maids and extended family would sometimes help with child rearing

In the city:

- * women would have greater options open to them: they would take care of the children, while some would choose to work
- * in the 1980's because of political problems and a civil war, there were more lay offs, but women got government jobs

In the country:

- * men and women would work together on the livestock and the farm; the work was shared

In Canada:

- * it is harder for the man to adjust to the Canadian lifestyle, but the men do help with child rearing, although not the housework
- * "it is very hard" for the woman here because she has to do a lot by herself, particularly since some family members may still be in Somalia
- * Somali women share in the day care here
- * economics were better before but there remains a tendency for the husband to provide for the family, while the woman takes care of the children
- * this is gradually changing, ie. the husband helps with the child rearing and the woman has the option to work
- * one woman stated that the literature she read in school was "wrong". It stated that Muslim women are slaves to their husbands and that they must give their money to their husbands. The woman stated that in fact if women do work they can keep their money--they can contribute to the family if they want, but it is still the man's responsibility to provide for the family

Grandparents' Role:

- * teach the grandchildren about Somali culture, language and religion
- * assist with babysitting
- * teach granddaughters about 'bad boys or bad men'
- * teach granddaughters how to cook
- * unfortunately, there are not many grandparents here in Canada: the Somalis are a new community

Marital Status and Sexuality

- * pre-marital sex is against the religion, the culture, and many parents' beliefs and values for their children
- * in Canada, the experience is (as stated by the younger members of the group) to know the boy well before the couple is allowed to see each other
- * dating is not allowed however, the boy is allowed to come to the house, and spend time with the girl and her family
- * the more respect teenagers have for their parents, the greater chance they would bring the boy home and not go out with him without the parents knowledge
- * interracial marriages generally are not accepted: however, if the culture is different at least the faith should be the same (Muslim)
- * one woman stated that teenage pregnancy is very shameful in the Somali community

F: Somali Men's Focus Group

Purpose of Children

In Somalia:

- * the more children the better, for various reasons: including economic survival ie. children help with the farming, therefore increasing production
- * of the Nomad people, 3 of 5 children might die, therefore it is safer to have more children
- * to love
- * because there are tribal disputes, the more children, the greater the defence available to protect your wealth/property against others

In Canada:

- * preserving the culture and religion
- * helping aging parents and not 'institutionalizing' them
- * for religious reasons: those who have children are rewarded by the religion
- * to teach the parents about the educational system, etc.
- * to love
- * for joy
- * children return the care their parents gave them, when they age

Sex of the Children

- * boys are preferred in Somalia: in the city, because they can be educated; and in the country, because they can defend the tribe and hence contribute to the safety of the tribe's people
- * because they will carry the family name
- * in Somalia, the family is happy if it is a boy; the family will spend more money if it is a boy; for girls not as much money is spent eg. father paid a lot for his mother

Family Size

- * in summary the group agreed that Somali families in Canada have an average of 3 children (ie the younger couples) unlike in Somalia where the average is 10 children

Family Roles

- * the woman is responsible for the "inside world"
- * the man is responsible to provide financial support or the "outside world"
- * grandparents are involved in the community and to teach the children about their faith and culture; they are the PEACE MAKERS in the community

In the city:

- * more women have dual roles (ie. work and look after the house) unlike in the country where women tend to be solely housewives

In Canada:

- * both the husband and the wife may work; but the wife still looks after the inside world and the husband the outside world

Marital Status and Sexuality

- * sex is only acceptable within the context of marriage: both for females and males

G: East Indian Focus Group

Purpose of Children

- * in the past, children were considered a gift from God
- * today, it is important to keep the family name, and that is the primary purpose of having children
- * one woman stated that one has a responsibility and an obligation to have children
- * children are needed so that they can take care of the parents when they get old--"we don't believe in nursing homes, like in Canada"

Sex of the Children

- * in India, there is still a preference for a boy
- * here, there is a variety of views: one view is that the preference is for a boy; the other response was that it is nice to have a mixed family
- * generally, it was believed that the cultural and religious norms are such that a boy is preferred, but a boy or a girl is accepted

Family Size

- * In India, in the past, there are 6-8 children on average, 10 is an exception today,
- * in Canada, East Indian couples are having 2-3 children on average

Family Roles

- * both in India and here: the husband is the financial supporter
- * in the past, the women's role was as a housewife; today, women's roles in the East Indian community are changing there is a belief that it is economically better for both the husband and the wife to be working and providing for their children
- * sometimes it is necessary for survival that both work

Marital Status and Sexuality

- * in India and here: the cultural and religious norms are that pre-marital sex is not acceptable for single, separated, divorced, or widowed persons
- * one woman put it that "married couples only have a license to do that"

ATTITUDES TOWARDS VARIOUS BIRTH CONTROL METHODS

	Vietnamese	Cambodian	Portuguese	Chinese	Somali Women	Somali Men	East Indian
Pill	Not liked very much because of side effects, ie. headaches, fever, mood changes, dizziness	Was used by some women in Cambodia, ie. those who could afford it; not a commonly used method	Two views arose: the pill is not a culturally or religiously supported method; "most teens today are using artificial birth control methods"	It is generally seen as safe in spite of some women's experiences of side effects	It was for married women only and very expensive in Somalia; some women don't like it because of side effects	Seems to be a good and safe method for women, and more comfortable for the man; people are reluctant to use it here because of religious beliefs	Although available in India, it is expensive and only used by rich women; considered the easiest method; it is easy to access here
IUD	This method is generally liked by Vietnamese women	This method was used but its form is different than here	Not a culturally or religiously approved of method ie. an artificial device	Some women use this method and prefer it	Not generally familiar with this method	Not used by Somali women unless they leave the country to get it	This is more acceptable and known but sometimes gives discomfort
Condom	Men don't tend to use or like the condom	One woman was familiar with this from her husband's use	Not discussed	Some men use the condom, but it is not commonly liked	Was available in some places; used also in relation to the prevention of STD's and AIDS	A popular and common method of use; easily available and inexpensive; helps prevent STD and AIDS; but not physically comfortable	Commonly used in India; an inexpensive method; machismo attitudes may be associated with non-use
Natural Family Planning (NFP)	Some like this method; no side effects	The group's view was that the rhythm method is difficult to understand	Two views arose: NFP is the only culturally and religiously approved method; vs. seen as 'old fashioned' by the younger members of the group	Although used by some women, it is not generally used because it is seen as not predictable	Used by some women; it is believed that some women would be willing to switch to other methods, if available	A preferred method for those with strong religious convictions	Used especially prior to the coming of artificial methods
Withdrawal						Girls/Young Women demand that the man withdraws	
Sterilization	Is seen as permanent; not popular; the woman should go for this not the man because his mood would be affected *see discussion examples, of regretted sterilizations	Some men have had this done	There is an increase in this method; considered a 'private' issue	Most women are sterilized in China; today men are sterilized also if other methods for women are not safe or effective	Not used as a common method of birth control; it is used when necessary, ie. if there is a health risk for the woman	Used by those who have finished having children or for health reasons; no forced sterilization occurs in Somalia	Done a lot in India; some see it as reversible; some see it as permanent; generally acceptable
Injections: Depo-Provera	Used in the South Vietnam; in Hong Kong and in refugee camps	popular in the refugee camps for the exchange of food					
Diaphragm	Not a generally available or popular method		Not approved of, ie. an artificial device	Not a popular method	Not familiar with this method	Not familiar with this method	

ATTITUDES TOWARDS ABORTION:

	Attitudes Regarding Abortion
Vietnamese	-abortion is against the religions (Buddhist and Catholic) and the culture -in North and South Vietnam, abortion services are available
Cambodian	-abortion is against the religion and is culturally undesirable; it is done, by some, when necessary
Portuguese	-abortion is not approved by the culture and/or religion -may still be occurring
Chinese	-abortion is forbidden by both the religion and culture -may still be occurring
Somali Women	-abortion is illegal in Somalia; it is unacceptable by both the culture and religion -if a mother's health is in jeopardy, abortion is permitted and is done
Somali Men	-abortion is unacceptable by the culture, religion and Somali government -Somalis here uphold these values about abortion, but at times it still happens
East Indian	-abortion is not approved by the culture and religion; in modern day India it is legal because of the population explosion, economic necessity, or if the couple wanted a boy -here, some will have an abortion out of economic necessity, or if their birth control method fails and they are not in a position to have children

ATTITUDES TOWARDS INFERTILITY:

	Infertility
Vietnamese	-not a good thing: the view used to be that it is the price to pay for doing bad, from the other life and it is the woman's fault -present thinking: there is a scientific, physical reason; it could be because of the man or the woman
Cambodian	-it is not a good thing
Portuguese	-"a couple who doesn't have children is a sad couple"
Chinese	-there is an assumption that it is the woman's fault and not the man's
Somali Women	-the woman tends to be blamed for infertility in the couple; an example of this is in Somalia the man can legally marry a second time, have two wives, and have children
Somali Men	-men can marry again and have children; if it is the man's fault the woman could divorce him but she cannot be married to two husbands -some Somalis believe it is God's will and leave it at that
East Indian	-in India, this used to be men's grounds for divorcing their wives -today, the culture and religion understands infertility, and family members offer support

CIRCUMCISION:

Somali Women	-in Somalia, a clinic was started by women concerned about circumcision -if circumcision was done according to religious norms there would not be as much cutting as is being done
Somali Men	-it is a must for men to be circumcised in order to be clean -it is not a must for women to be circumcised, according to the religion, but it is considered a good thing -circumcision is seen as part of the Somali culture and Muslim faith

ATTITUDES TOWARDS AIDS AND SEXUALLY TRANSMITTED DISEASES:

	AIDS/Sexually Transmitted Diseases
Vietnamese	-AIDS is known as SIDA (Seta); there is increased awareness through education; it is transmitted through sexual intercourse
Cambodian	-the women in the group said their husbands informed them about STD/AIDS ie. that you can get it from sitting on an unclean toilet seat; the women said that these diseases can be cured by applying mud/soil to the infected area and by eating a particular green vegetable *see discussion section
Portuguese	-there is awareness about these concerns within the community; education is still needed on this; the younger members believed in being safe
Chinese	-there is awareness in the community about both; not of great concern because of monogamy
Somali Women	-there was a lot of information and advertising in Somalia about both; more needs to be known
Somali Men	-there is general familiarity amongst Somali people due to education in Somalia and here; some don't know about this; precautions are taken such as having monogamous relationships, abstinence, and using condoms
East Indian	-it is a new issue for East Indians in Canada; it is not a particular concern prior to marriage since sex is not acceptable, nor in marriage due to monogamy - "hope that he doesn't have any diseases" -some "haven't thought about it"

THE MEDICAL AND SOCIAL SYSTEM HERE (RESPONSIVENESS TO AND FLEXIBILITY OF):

Focus group participants identified difficulty in accessing the system because of language barriers, cost considerations, a lack of cultural interpreters and racially and culturally diverse doctors, differences in medical systems from their countries of origins, and experiences of racism and discrimination.

Vietnamese	-not easy to access if you don't know the language or have a doctor that speaks your language -translators are used but are not good
Cambodian	-'okay' *see discussion
Portuguese	-there are few Portuguese-speaking doctors in Hamilton -family members are used to translate when going to a doctor -those who don't speak English (often the older generation) accessing the system is <u>very difficult</u>
Chinese	-some don't know where to get information and access the system; -others access the system through their doctors -a more holistic service approach is needed eg. home visits -more women doctors and gynaecologists are needed -a family planning worker should go to the hospital after a woman gives birth
Somali Women	-information sharing about resources occurs in the community -it is okay for some to access the system through their family doctor -professional interpreters are not generally used, but rather family and friends -bus transportation/routes are difficult -it is hard to access if one does not know the language -cost is often a barrier -workers should be non-judgmental about the person's culture/religion -it is especially hard to access services in family planning because of embarrassment; there is no confidentiality if an interpreter is needed; many health care professionals are men and this issue is more easily discussed with females
Somali Men	-there are no practising Somali speaking doctors in Hamilton; -there are differences between medical systems here and in Somalia; -it is especially difficult for those who don't speak English
East Indian	-cost of medicine is a concern regarding access -for those who don't speak English it is very hard -many will enter the system through emergency wards -many experience racism and discrimination

Education for Children and Teens:

- * children and teens need to be educated about the issues related to birth control and family planning properly; not through the confusing and 'bad' messages they get on television, for example, shows dealing with sex and violence, sexual affairs
- * Portuguese parents are saying that teens should be informed about natural family planning
- * the teens in the group, however, stated that in general natural family planning is seen as "old fashioned" and artificial birth control is more accepted amongst girls in their age group

Education for both the Parents with their Children/Teens (Inter-Generational):

- * the purpose of the sessions would be to improve parent-child communication re: sexuality/birth control/family planning through a greater understanding of each other's position--the older generation's value and belief in natural family planning and some of the younger generation's value and belief in artificial birth control and natural family planning
- * sessions should have information on natural family planning "more education doesn't mean that artificial birth control is right"
- * the group agreed that there is difficulty talking about these issues within the family ie. parents to teens and teens to parents
- * the group agreed that inter-generational sessions were a basic starting point in education
- * the teens should be 11 years of age and older

D: Chinese Focus Group

EDUCATION/INFORMATION

Groups:

- * need to know more about birth control and family-planning issues, targeting the ages of 15 years old and up.
- * need education on 'how to raise children': this would attract couples.
- * educational sessions for couples prior to marriage
- * education would not be effective at a community centre as this is too public and embarrassing for individuals; also the Chinese are not geographically concentrated in one part of the city

Pamphlets:

- * pamphlets on birth control in the Chinese language should be available in drug stores, doctor's office, Ontario Welcome House, Manpower Offices; they should include a sticker of Planned Parenthood's location, phone number etc.

Community Worker:

- * greater accessibility to service through a Chinese outreach worker who could do home visits which would increase privacy and comfort
- * a worker from Planned Parenthood should go to the hospital after a woman gives birth to inform about birth control and family planning

Translation of Facts of Life Line:

- * a Chinese version of "The Facts of Life Line"
- * this would be less embarrassing and ensure confidentiality

ASSISTANCE IN ACCESSING THE MEDICAL AND SOCIAL SERVICE SYSTEMS

- * need to know more about Planned Parenthood's services.
- * need a holistic approach to service, (for example, looking at various issues in relation to family planning, not just the type of birth control method used)
- * free IUD's and condoms
- * need more women doctors and gynaecologists

ASSISTANCE IN INVOLVING MEN TO PARTICIPATE EQUALLY

- * Need more work done to encourage men to take greater responsibility for family planning and child rearing eg. men don't generally want to be sterilized or use the condom due to a male ego.

E: Somali Women's Focus Group

EDUCATION/INFORMATION

Groups:

- * to prevent an unwanted pregnancy
- * to explain the methods of birth control, including a thorough explanation of the side effects, advantages and disadvantages of each method
- * pictures of birth control methods
- * separate groups for men and women initially, followed by additional sessions as mixed groups

- * education could begin at 15 years and up, younger if the girl has her period
- * meetings should be organized in the community with racially and culturally sensitive Planned Parenthood staff:
- * these should occur at the community centre, where Somalis already have access

Pamphlets:

- * need written information in Somali language: there are no pamphlets presently written about birth control and family planning, AIDS and sexually transmitted diseases
- * the group perceived that a lot of Somalis don't know about birth control available in Canada, and it would be useful to have this information in both Somali language and English

Translation of Facts of Life Line:

- * need the Facts of Life Line translated in Somali
- * this would help to break down taboos yet is confidential

ASSISTANCE IN ACCESSING THE MEDICAL AND SOCIAL SYSTEMS

- * need to know where and how to access the medical system regarding family planning/birth control
- * need to educate how to use the transportation system
- * need assistance in covering costs on birth control methods
- * the group thought the idea of a mobile unit would help people access the services they need especially when people can't get to a clinic and would also be more convenient for some

RACIAL AND CULTURAL SENSITIVITY FROM CAREGIVERS WITHIN THE SYSTEM

- * the helper must make the individual comfortable
- * the helper must not judge the person's decisions
- * the helper must not judge the person's culture and religious beliefs
- * workers must understand Somali parents worry about the influences and possible effects of this society on their children, in losing their traditional cultural and religious values

F: Somali Men's Focus Group

EDUCATION/INFORMATION

Groups:

- * run workshops/educational sessions which are sensitive to the cultural and religious norms of the Somali people, while still providing information on birth control, sexually transmitted diseases and AIDS
- * education should encourage prevention

- * the goal would be to provide information and to reach an understanding, while breaking down cultural barriers
- * educational sessions would begin at age 10 years and older, when children are capable of understanding the issues
- * educational sessions should take place for men and women separately, so as to avoid embarrassment and for religious reasons
- * some mixed group sessions should also be available
- * the religious position must be made clear in relation to sexual activity
- * teens should know about this but answer to God for their behaviours--education should not encourage sexual activity
- * all aspects of this topic/options should be presented and the consequences of each discussed
- * adults and parents should be targeted first, and then they would educate their children
- * the final group consensus was to present all aspects of this topic: the religious and cultural expectations should be made known in relation to family planning/birth control practices and consequences. People would then be well informed and would be free to make their own conscious decisions.

Community worker:

- * the group agreed that two people should provide the education: the outreach worker should be Somalian who knows the rules of the Muslim faith; while the second person would be an expert in the medical aspect of birth control and family planning
- * the group agreed that it could be one person if that person was familiar with both aspects

Pamphlets:

- * the pamphlet would discuss the different birth control methods that are available in Somali language

Translation of Facts of Life Line:

- * the group thought that this confidential service would be useful in translating taped recorded messages in the Somali language

ACTIVE PARTICIPATION ON THE BOARD AND COMMITTEES OF PLANNED PARENTHOOD

- * several men in the group were willing to assist in any of the above suggestions as necessary
- * individuals were willing to devote their time voluntarily to help their community

G: East Indian Focus Group

EDUCATION/INFORMATION

- * groups should not be mixed because women's views would be influenced by the men's

Translation of Facts of Life Line:

- * the Facts of Life Line should be translated into Hindi

Community Worker:

- * must hire from within the community to best meet its needs
- * the worker should be trained by the agency, as volunteer at first only, but later should be paid
- * transportation might be a problem
- * language barriers prevent access
- * financial problems make accessing the system/service more difficult
- * don't feel understood by other communities, mainstream services
- * East Indians don't access the system because they experience racism and discrimination
- * interpreters, as they are currently used, do not really understand and explain thoroughly

ACTIVE PARTICIPATION ON THE BOARD AND COMMITTEES OF PLANNED PARENTHOOD

- * should have East Indian Board members to represent the community, and make decisions

EVALUATION OF FOCUS GROUP SESSIONS

The following are direct quotes, taken from all of the focus groups:

INFORMATION SHARING:

- * Learned some things
- * Learned a lot about the different methods
- * I did not know about all the methods like the diaphragm
- * Had not heard about Planned Parenthood services before
- * It was time for me to learn
- * I have heard about the methods, but I didn't know about the consequences
- * Helpful even for single women to prepare for the future
- * Have to have more people learn about the services
- * This is old information, I have had my family
- * I would talk about this with my friends, but today I talked and saw this with pictures

FEELINGS:

- * Not difficult to talk about
- * Glad to have been able to express these thoughts/feelings since sex/sexuality issues are generally taboo and not talked about
- * Glad to have helped
- * It was a relaxed atmosphere
- * Sometimes embarrassed
- * Ethnic groups should not just be educating mainstream organizations
- * I am surprised that the group was so talkative
- * I have two teenagers, one which is in the group today. I worried about how I was going to bring this topic up to them. This group helped to give my daughter the information about this topic

CONCERNS:

- * There were few numbers present ie. people are tired, they are busy or working late, poor time of the day, we will try again
- * I don't know if I should have participated since I am speaking for people who aren't in the group--ie. older people who are better and more qualified to speak about this issue, because I am young and inexperienced
- * Research overall does not reflect all the people in a cultural group

CONSENSUS:

- * Happy that we reached an agreement and a solution

OTHER:

- * Thank you
- * Want more meetings

ADDITIONAL DATA OBTAINED

Professionals' Feedback

With the exception of one mainstream organization, which was concerned about the potential for eugenics, all responses from professionals proved supportive. Additional requests were made for a Planned Parenthood speaker to attend ESL classes, and meetings to discuss the research. There was further acceptance by the Multicultural Health Coalition to be part of their April 1992 national conference.

Facts of Life Line

There was a significant increase in the use of the Facts of Life Line, a confidential phone-in service, with prerecorded messages in English on a variety of topics dealing with sexuality issues, during the months in which the focus groups were held, and information cards about this service were distributed.

During 1990, an average of 500 calls a month were made. In August and September 1991, the calls for inquiries increased: 724 for the former, and 1,187 for the latter. This was followed by a decrease in October to 400. There was no other attributing factors which were found for this increase except the distribution of information cards to focus groups.

Questions posed by Racially and Culturally Diverse Individuals and Groups to the Researcher

The following list outlines the kinds of questions which were asked to the researcher, during this interactive process:

- * What does Planned Parenthood do?
- * How long has Planned Parenthood existed?
- * Are the doctors qualified?
- * What methods of birth control are used in Canada?
- * Is Depo-Provera used here?
- * What is withdrawal?
- * What is a hysterectomy?
- * What can my brother who is infertile and overseas do?
- * What is a sponge?
- * What are foams and jellies?
- * Is your service OHIP covered?
- * Who is covered under OHIP?
- * Can I have some written information to give to my clients because it is difficult to talk to them because of a language barrier?

DISCUSSION AND SUMMARY OF REPORT

Objectives Achieved:

The information, concerns, needs, and recommendations made by the racially and culturally diverse participants have been accurately reported in this research. These views are valid in their own right. While we cannot generalize to say that this group of racially and culturally diverse persons represents the views and beliefs of all racially and culturally diverse persons, we can from these findings begin a long-term process of addressing and understanding the issues of family planning. With the experiences, perspectives, needs and leadership of the racially and culturally diverse, this current knowledge will be refined further through the implementation of the recommendations.

The general objective of this project in determining the family planning needs (if any) of racially and culturally diverse communities was achieved through those participants from the Vietnamese, Cambodian, Chinese, Spanish, Somali, Portuguese, and East Indian communities. Women from all these communities had an opportunity to tell their past and present experiences in family planning. Men from the Somali and Spanish communities were also able to present their views. These participants identified their needs through the opportunity to express their past and present family planning experiences--by placing these experiences into their psycho-social, economic, religious, cultural and political context.

The end result was the identification and increased understanding of:

- * the experiences and views of racially and culturally diverse persons in the area of family planning services;
- * specific attitudes towards preferred birth control methods;
- * barriers in relation to accessing family planning services (socio-economic, systemic discrimination; cultural and religious differences relative to mainstream organizations etc.)

As well as these important points, the action-oriented nature of the research initiated strategies necessary for change, resulting in many of the recommendations contained in this report.

The agency survey supported the focus group and key informant findings particularly on the issue in the difficulty in accessing mainstream organizations and availability of racially and culturally appropriate services in family planning. Agencies made it clear that there is a need for greater information and accessibility to birth control services for Hamilton's racially and culturally diverse groups.

Myths Dispelled:

This section identifies myths and stereotypes held by the general population regarding racially and culturally diverse communities in regard to family planning, which were not supported by the racially and culturally diverse participants, in this research.

Myth #1: Racially and culturally diverse communities are ignorant of family planning.

The research found that, contrary to stereotypes, racially and culturally diverse participants showed a similar knowledge base of family planning issues and birth control methods, to the general population. While some used the term itself, others described experiences relating to the option of having children as well as the timing of having children. Women's wide range of experiences included 'no planning', and in some cases struggling with an unwanted pregnancy; to natural family planning (rhythm method); to the use of artificial birth control methods. All the focus groups participants were familiar with the pill, IUD, condom, and sterilization methods; only some were unfamiliar with the diaphragm. Some participants made mention of the use of Depo-Provera, for example, in the refugee camps. This diversity of experiences was influenced by socio-economics, religious or moral convictions, cultural norms, politics, availability and accessibility of such methods and services.

Myth #2: Racially and culturally diverse families have and want 'large' numbers of children.

Norms are constantly changing in regard to family size. They are subject to individual, cross-cultural, economic, religious, and political influences.

The majority of women participants indicated wanting 'smaller' family sizes in Canada--to ensure a 'better' life for their children. Average family sizes desired are noted through the consumer questionnaires. Families with 'many' children in Canada have, in most cases, immigrated here with their children. Furthermore, for many in Canada, the harshness of their socio-economic situation in not securing employment, or having to accept low-paying jobs means that many have had to abandon the idea of 'large' families, as a means of economic and social survival.

Priority was not seen in terms of the numbers of children but rather in their ability to have social opportunities which the parents never had, and in the family achieving overall financial stability.

Myth #3: Racially and culturally diverse women do not participate, have an interest in, or even think about reproductive issues because their priorities are more centred around survival issues.

In fact, family planning (in whatever form) was very much an issue of importance for the majority of women in the focus groups. The participants identified, both in Canada and in their country of origin, that it is possible to give equal value to survival issues and family planning. For example, in order to survive in some agricultural communities, more children and larger families were needed to assist with the labour.

The participants were very much concerned with their ability to provide and care for their children. Past and present examples were given of women who induced abortions or miscarriage out of this concern. The desire for and goal of financial stability and healthy children was identified as universal, while the means to obtaining this goal may differ.

Myth #4: Some cultures use abortion as a method of birth control.

Contrary to this perception, which arose from some participants, there was consensus by all focus group participants that abortions are neither acceptable nor desirable, both in their country of origins and in Canada.

Factors Affecting Family Planning Decisions

Universal:

Many of the issues which arose are those which family planners have always addressed, and continue to address. Confidentiality issues are worrisome for individuals and crucial to this very personal and sensitive issue. A general lack of assertiveness in actively accessing family planning services is often rooted in anti-family planning messages. Some religions, sexist attitudes, and media influences restrict women from their right to fully exercise their reproductive options. In some cases, family planning is seen as the sole obligation of women. This puts tremendous amounts of pressure and responsibility on women.

The relationship between family planning and economics is long established. Economic hardship has often limited personal options in family planning decisions.

As values change between generations, conflicts occur. The need for sexuality education, yet the opposition to it, based on the argument that it leads to promiscuity, continues despite research which has proven this false. Further opposition to family planning has tended to incorrectly equate this term with being anti-children, with no just cause.

Specific to the Racially and Culturally Diverse Populations:

The above family planning issues were all identified in the research. For example misinformation presented by participants in the focus groups included:

- * Sexually transmitted diseases can be transmitted on uncleaned toilet seats.
- * Sterilization will cause personality changes in men.
- * Sexually transmitted diseases can be treated with mud and soil treatments and by eating certain vegetables.

While all of these statements are false, they are representative of the type of misinformation that is common amongst all people, regardless of their racial or cultural background.

From a family planning agency's point of view, these universal factors alone create serious challenges to the delivery of family planning services; however, the additional struggles particular to the racially and culturally diverse create even greater barriers to accessibility.

Past Oppressive Experiences

Past oppressive experiences, through population control programs leading to anti-choice messages, were identified as a barrier to accessing family planning services in Canada by key informants, and some focus group participants. The needs of the refugee population were seen to be particularly neglected in all service delivery, and issues of rape, torture, and repeated abuse have serious implications for family planning service delivery.

Language Barriers

Language barriers were identified as either restricting or denying access to health and social services in Canada. The lack of cultural interpreters and diverse health and social service professionals, and availability of culturally and racially appropriate information in all languages were two examples of ways in which language barriers are perpetuated.

Cultural and Religious Influences

Common themes arose in attempting to understand the relationship between such factors as religion and culture, in terms of racially and culturally diverse communities and family planning decisions. Many examples were given of how values can restrict access to family planning services, from agency persons, key informants, and the focus group participants. Sexism, integrated with oppressive cultural and religious values, posed additional restrictions to women's equality.

While "culture" and "religion" have proven to be important to this research, their application has also been in a different light.

While in some cases, religion and culture were described by focus group participants as barriers to maximum options, in other cases focus group participants noted cultural and religious influences in how family planning decisions are made, the means chosen, as well as the need for greater sensitivity from mainstream services.

What all racially and culturally diverse persons supported was the need to access family planning services, as marginalized members of society, rather than from a position of needing services more than any other group--(since 'more' implies a deficiency). Hence, what is confirmed by this research is that racially and culturally diverse groups need equality of opportunity to accessing and receiving quality health care information and services in family planning and other sexuality topics, in general.

Economic Barriers

Economic issues (or barriers) and their relationship to reproductive options were recurring themes which emphasized inequities between classes. In economic systems in which the country's chief resources are controlled by the wealthy or the minority of persons, the wide range of birth control methods which could be available are in fact limited to those who can afford them. For instance, often, the condom and the IUD's were popular and cited as the more widely available methods to the majority, as opposed to the pill. These economic disadvantages are increased by racial discrimination and a lack of recognition of skills (ie. professional credentials from country of origin).

Access to Services

The focus group participants described a Canadian social and health system which is slow in responding to the needs of the racially and culturally diverse communities. This was supported in some discussions with other participants who made stereotypic assumptions about some cultures (for example, unique cultures and races were identified as the same) or who believed in any one of the four myths discussed earlier.

Furthermore, for many racially and culturally diverse communities, the medical and social systems here are very different from their country of origins--in how illness, health, and needs are defined and prioritized. For those persons, coming from holistic or family oriented perspectives, categorization of needs and individualization echoes very differently. Some people who choose to use natural as oppose to artificial birth control methods may be judged as having values which are behind Western standards. It is often at such points of contention that discrimination flourishes, as racially and culturally diverse persons may be criticized for their way of thinking and experiences. To provide appropriate programming, values must be respected within the full range of providing sexuality and reproductive options--including all available birth control methods, and their advantages and limitations.

It is crucial that in achieving the needs of these groups in the area of family planning we must first address the barriers to accessing services.

The issue of family planning must be relevant and owned by these communities if long-term changes are to occur. Simultaneously, we must continue to address the more general issues which restrict sexuality education and family planning from being a basic human option for those who wish to exercise it.

MAIN ISSUES WHICH WERE CONFIRMED

- * The initial assumption that racially and culturally diverse groups are marginalized and do not have sufficient access to family planning information and services has been supported by the focus groups, the key informants and agency personnel. Furthermore, racially and culturally diverse persons want to be included in the process of change; and to be sincerely respected for their input.
- * That services in the area of family planning and birth control, because of its intimate and personal nature, are especially difficult to access. The need for safe, affordable and accessible services which maximize options and explain the risks and benefits of all methods, for racially and culturally diverse populations was reinforced by the focus group discussions, key informant interviews, and agency survey.
- * That one's health cannot be isolated from one's history and/or environment.
- * This research supports action research principles which identify experiences which can lead to strategies for changes.

We must continue to be clear, in this process, as to the political motivations of this issue and in its implementation. The experiences of the racially and culturally diverse communities must be continuously encouraged and placed into their political context with a careful analysis as to race, class, culture, religious and moral convictions etc. Furthermore, community ownership by the racially and culturally diverse communities is necessary if long-term systemic and attitudinal changes are to be achieved.

FUTURE DIRECTION

Future direction will begin to implement the recommendations made in this report.

What is anticipated in the course of this implementation is further definition as to the needs of Hamilton's racially and culturally diverse communities, as defined by those persons, in the field of family planning.

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APPENDICES A-1 and A-2:

A-1: 1986 Census, Total Population of Hamilton-Wentworth, By Place of Birth

A-2: 1986 Census, Total Population of Hamilton-Wentworth, By Selected Mother Tongue, Gender and Census Division

Population by Place of Birth, 1986 - PAGE 1
POPULATION SELON LE LIEU DE NAISSANCE, 1986

Area/AIRE: HAMILTON

Place of Birth / LIEU DE NAISSANCE		TOTAL	%
TOTAL		551,555	100.00
Born In Canada	/ NEE A L'INTERIEUR DU CANADA	416,395	75.49
Ontario	/ ONTARIO	365,945	66.35
Other Provinces	/ AUTRES PROVINCES	50,450	9.15
Born Outside Canada	/ NEE A L'EXTERIEUR DU CANADA	135,160	24.51
Total North America	AMERIQUE DU NORD TOTAL	422,270	76.56
Canada	/ CANADA	416,395	75.49
United States	/ ETATS-UNIS D'AMERIQUE	5,875	1.07
Europe	EUROPE	111,255	20.17
United Kingdom	/ ROYAUME-UNI	40,010	7.25
Italy	/ ITALIE	18,690	3.39
Yugoslavia	/ YUGOSLAVIE	9,455	1.71
Netherlands	/ PAYS-BAS	7,175	1.30
Poland	/ POLOGNE	6,710	1.22
Total Germany	/ ALLEMAGNE TOTAL	6,590	1.19
West Germany	/ ALLEMAGNE DE L'OUEST	5,375	
East Germany	/ ALLEMAGNE DE L'EST	1,220	
Portugal	/ PORTUGAL	5,135	0.93
USSR	/ URSS	4,255	0.77
Hungary	/ HONGRIE	3,400	0.62
Greece	/ GRECE	2,175	0.39
Czechoslovakia	/ TCHECOSLOVAQUIE	1,695	0.31
Austria	/ AUTRICHE	1,235	0.22
Rep. of Ireland (Eire)	/ REPUBLIQUE D'IRLANDE (EIRE)	1,150	0.21
Romania	/ ROUMANIE	770	0.14
France	/ FRANCE	540	0.10
Belgium	/ BELGIQUE	490	0.09
Denmark	/ DANEMARK	475	0.09
Spain	/ ESPAGNE	250	0.05
Malta	/ MALTE	195	0.04
Finland	/ FINLANDE	190	0.03
Switzerland	/ SUISSE	175	0.03
Cyprus	/ CHYPRE	165	0.03
Sweden	/ SUEDE	150	0.03
Norway	/ NORVEGE	65	0.01
Bulgaria	/ BULGARIE	40	0.01
Luxembourg	/ LUXEMBOURG	25	0.00
Liechtenstein	/ LIECHTENSTEIN	20	0.00
Gibraltar	/ GIBRALTAR	15	0.00
Asia	ASIE	9,760	1.77
India	/ INDE	2,515	0.46
Indo-China	/ INDOCHINE	1,975	0.36
Viet Nam	/ VIET NAM	1,445	
Laos	/ LAOS	230	
Kampuchea	/ KAMPUCHEA	205	
Thailand	/ THAILANDE	100	
Middle East	/ MOYEN-ORIENT	1,220	0.22
Turkey	/ TURQUIE	260	
Lebanon	/ LIBAN	215	

Population by Place of Birth, 1986 - PAGE 2
POPULATION SELON LE LIEU DE NAISSANCE, 1986

Area/AIRE: HAMILTON

Place of Birth / LIEU DE NAISSANCE			TOTAL	%
Israel	/	ISRAEL	200	
Iran	/	IRAN	180	
Iraq	/	IRAQ	165	
Jordan	/	JORDANIE	85	
Syria	/	SYRIE	65	
Afghanistan	/	AFGHANISTAN	35	
Philippines	/	PHILIPPINES	1,045	0.19
Republic of China	/	REPUBLIQUE POP. DE CHINE	1,005	0.18
Hong Kong	/	HONG KONG	835	0.15
Pakistan	/	PAKISTAN	395	0.07
Total Korea	/	COREE TOTAL	375	0.07
South Korea	/	COREE DU SUD	365	
Japan	/	JAPON	95	0.02
Indonesia	/	INDONESIE	85	0.02
Malaysia	/	MALAISIE	80	0.01
Sri Lanka	/	SRI LANKA	60	0.01
Burma	/	BIRMANIE	30	0.01
Singapore	/	SINGAPOUR	20	0.00
Taiwan	/	TAI-WAN	15	0.00
Macao	/	MACAO	10	0.00
Caribbean Guyana		CARAIBES ET GUYANA	4,205	0.76
Jamaica	/	JAMAIQUE	1,985	0.36
Guyana	/	GUYANA	950	0.17
Trinidad & Tobago	/	TRINITE ET TOBAGO	700	0.13
Barbados	/	BARBADE	230	0.04
Grenada	/	GRENADA	80	0.01
Cuba	/	CUBA	55	0.01
Bermuda	/	BERMUDES	45	0.01
Dominica	/	DOMINIQUE	40	0.01
Netherlands Antilles	/	ANTILLES NEERLANDAISES	40	0.01
St. Lucia	/	SAINTE-LUCIE	20	0.00
Haiti	/	HAITI	15	0.00
Dominican Republic	/	REPUBLIQUE DOMINICAINE	15	0.00
St. Vincent/Grenadines	/	SAINTE-VINCENT-ET-GRENADINES	10	0.00
St. Christopher & Nevis	/	SAINT-CHRISTOPHE-ET-NEVIS	10	0.00
Africa		AFRIQUE	1,275	0.23
Rep. of South Africa	/	REPUBLIQUE D'AFRIQUE DU SUD	420	0.08
Egypt	/	EGYPTE	220	0.04
Uganda	/	OUGANDA	145	0.03
Kenya	/	KENYA	85	0.02
Ghana	/	GHANA	70	0.01
Tanzania	/	TANZANIE	65	0.01
Zimbabwe	/	ZIMBABWE	40	0.01
Ethiopia	/	ETHIOPIE	35	0.01
Morocco	/	MAROC	30	0.01
Angola	/	ANGOLA	30	0.01
Algeria	/	ALGERIE	20	0.00
Nigeria	/	NIGERIA	20	0.00
Zambia	/	ZAMBIE	20	0.00
Mauritius	/	MAURICE	20	0.00
Tunisia	/	TUNISIE	15	0.00

Population by Place of Birth, 1986 - PAGE 3
POPULATION SELON LE LIEU DE NAISSANCE, 1986

Area/AIRE: HAMILTON

Place of Birth / LIEU DE NAISSANCE		TOTAL	%
South America	AMERIQUE DU SUD	810	0.15
Chile	/ CHILI	190	0.03
Argentina	/ ARGENTINE	190	0.03
Colombia	/ COLOMBIE	90	0.02
Venezuela	/ VENEZUELA	85	0.02
Ecuador	/ ECUATEUR	80	0.01
Brazil	/ BRESIL	80	0.01
Peru	/ PEROU	55	0.01
Suriname	/ SURINAME	15	0.00
Central America	AMERIQUE CENTRALE	600	0.11
El Salvador	/ EL SALVADOR	265	0.05
Mexico	/ MEXIQUE	160	0.03
Nicaragua	/ NICARAGUA	80	0.01
Honduras	/ HONDURAS	50	0.01
Guatemala	/ GUATEMALA	20	0.00
Costa Rica	/ COSTA RICA	20	0.00
Australia + Islands	AUSTRALIE + LES ILES	490	0.09
Australia	/ AUSTRALIE	395	0.07
New Zealand	/ NOUVELLE-ZELANDE	70	0.01
Fiji	/ FIDJI	15	0.00
Republic of Belau	/ REPUBLIQUE DE BELAU	10	0.00
Other	AUTRES	20	0.00

1986 CENSUS FILE: WT86A01

POPULATION BY SELECTED MOTHER TONGUE AND SEX - 100%

Source: Ethnocultural Data Base, Ontario Ministry of Citizenship
[5th Floor, 77 Bloor W., Toronto, M7A 2R9; 416-965-5280]

APPENDIX B—KEY INFORMANT'S INTERVIEW AGENDA:

KEY INFORMANT'S INTERVIEW AGENDA
(applied in a semi-structured format)

1. What is/has been your personal and/or professional experience in relation to:
 - a. racially and culturally diverse groups or family planning and/or both
 - b. socio-economics in relation to family planning
2. What barriers to access do you feel may currently exist regarding family planning services and the racially and culturally diverse in Hamilton?
3. In your view, what values and/or issues are important towards an understanding of various racially and culturally diverse groups and family planning issues, and services?

(eg. social, religious, economic, cultural, political, Western, family roles, sexism, racism, marital status, confidentiality, issues of rights, community development etc., etc.)
4. In your view, which racially and culturally diverse groups might be lacking in an opportunity to access family planning services (include as a possibility your own ethnic community). Please explain.
5. Do you wish to be part of the organizing of a focus group for your community?

OR

Please suggest other persons to contact regarding community organizing on this issue.

KEY INFORMANT'S INTERVIEW AGENDA
(Applied in a semi-structured format)

1. What has been your personal and/or professional experience in relation to:
 - a. racially and culturally diverse groups or family planning and/or both
 - b. socio-economics in relation to family planning
 2. What barriers to access do you feel may currently exist regarding family planning services and the racially and culturally diverse in Hamilton?
 3. In your view, what values and/or issues are important towards an understanding of various racially and culturally diverse groups and family planning issues, and services?

(eg. social, religious, economic, cultural, political, Western, family roles, sexism, racism, marital status, confidentiality, issues of rights, community development etc., etc.)
 4. In your view, which racially and culturally diverse groups might be lacking in an opportunity to access family planning services (include as a possibility your own ethnic community). Please explain.
 5. Do you wish to be part of the organizing of a focus group for your community?
- OR
- Please suggest other persons to contact regarding community organizing on this issue.

INSTRUCTIONS

In the following consumer questionnaire you will find 40 questions.

You need to either circle the answer which applies to your situation, or fill in the blanks, with a short answer.

You do not need to have your name, unless you want additional information from Market Research.

Thank you for your participation.

APPENDIX C—CONSUMER QUESTIONNAIRE:

Name _____ English _____ Nationality _____

Place of birth _____ Vietnamese _____

Cambodian _____

Portuguese _____

Chinese _____

Somali _____

Spanish _____

INSTRUCTIONS:

In the following consumer questionnaire you will find 40 questions.

You need to either circle the answer which applies to your situation, or fill in the blanks, with a short answer.

You do not need to leave your name, UNLESS you want additional information from Planned Parenthood.

Thank-you for your participation.

Name: _____ (optional)

Phone #: _____ (optional)

MULTICULTURAL NEEDS ASSESSMENT
CONSUMER QUESTIONNAIRE

CIRCLE THE ANSWER

MALE

FEMALE

Q-1 What is your Ethnic Origin?_____

Q-2 What country were you born in?_____

Q-3 How long did you live there?_____

Q-4 Did you live in the country or the city?_____

Q-5 Where did you live before you came to Canada?_____

Q-6 How long did you live there?_____

Q-7 When did you come to Canada?_____

Q-8 When did you come to Hamilton?_____

Q-9 What language(s) do you speak, fluently?_____

Q-10 What language(s) do you read/write, fluently?_____

Q-11 Are you:

- | | |
|---------------|--------------|
| a. single | d. separated |
| b. married | e. divorced |
| c. common-law | |

Q-12 What is your religion?_____

Q-13 Are you currently practicing your religion?

YES

NO

Q-14 What is your age range?

- | | | | |
|----------|----------|----------|---------|
| 1. 16-25 | 2. 26-30 | 3. 31-35 | |
| 4. 36-40 | 5. 41-50 | 6. 51-64 | 7. 65 + |

Q-15 What level of schooling did you complete?_____

Q-16 What was your occupation before coming to Canada?_____

Q-17 What is your occupation now?_____

Q-18 Which of the following categories best describes your total annual income?

- | | |
|-------------------------|-------------------------|
| a. less than \$5,000 | b. \$6,000 to \$9,999 |
| c. \$10,000 to \$19,999 | d. \$20,000 to \$29,999 |
| e. \$30,000 to \$39,999 | e. over \$40,000 |

Q-19 How many children do you have?_____

Q-20 How many children do you want to have?_____

Q-22 As you know, some people practice birth control and some people do not. Did you practice birth control in your country of origin?

YES

NO

b. If yes, what did you use?_____

Q-23 Do you practice birth control now?

YES

NO

If NO, go to QUESTION 27 and continue

Q-24 What type of "birth control" ? PLEASE CIRCLE

- | | |
|----------------------------|-------------------------|
| a. birth control pills | b. diaphragm |
| c. condom | d. foams and jellies |
| e. IUD | f. withdrawal |
| g. Natural Family Planning | h. contraceptive sponge |
| i. sterilization | j. other_____ (specify) |

Q-25 Are you happy with the above type?

YES

NO

Q-26 If no, why not? _____ (specify)

b. Would you like to try another method?

YES

NO

Q-27 If you are not practicing birth control, why not?

- | | |
|---------------------------------------|-----------------------------|
| a. don't know where to get any | b. want (more) children |
| c. it is against your religion | d. you had a bad experience |
| e. you don't feel its physically safe | f. too expensive |
| g. you don't trust it will work | h. too hard to use |
| i. spouse doesn't want you to | j. cannot get pregnant |
| k. not sexually active | l. sterilization |

Q-28 Do you have a doctor you can easily call?

YES NO

Q-29 If yes, does your doctor speak the same language you do?

YES NO

Q-30 Do you understand your doctor when he/she speaks to you?

YES NO

Q-31 Would you feel comfortable to ask your doctor about birth control?

YES NO

b. If no, why not? _____ (specify)

Q-33 Have you ever used an interpreter (someone to help you explain to others in the language you cannot speak) for anything?

YES NO

Q-34 If you were to go to someone for help with family planning would you need an interpreter?

YES NO

Q-35 Would you know where to get an interpreter?

YES NO

Q-36 Would you feel comfortable using an interpreter to talk about family planning?

YES NO

Q-37 Who do you talk to about birth control now?

- | | |
|---|---|
| a. spouse | b. doctor |
| c. midwife | d. relatives |
| e. your community
centre | f. friends |
| | g. someone from your religious
group or place of worship |
| h. you don't talk to
anyone about it | i. other _____ |

Q-38 Who would you feel most comfortable talking to about birth control?

- | | |
|--|---|
| a. friends | b. relative |
| c. spouse | d. a stranger |
| e. doctor | f. nurse |
| g. midwife | h. someone who knows your
language and culture |
| i. someone from your
religious group or
place of worship | j. other _____ |

b. In what setting would you feel most comfortable in to talk about birth control?

- | | |
|---------------------------------|--------------------------------|
| a. in your own home | b. in your parents home |
| c. in your relatives
home | d. in your friends home |
| e. in a doctors office | f. in a family planning clinic |
| g. in religious
surroundings | h. in a hospital |
| i. in a community
centre | j. other _____ |

Q-39 Under what conditions would you be most comfortable to talk about birth control?

- | | |
|------------------------------|---------------------------------------|
| a. alone | b. as a couple |
| c. as a family | d. in a group with people
you know |
| e. in a group with strangers | |

Q-40 What is your status in Canada?

1. Refugee Claimant
2. Minister's Permit (Ministry of Immigration)
3. Landed Immigrant? Permanent Resident
4. Family class/ Assisted Relative
5. Citizen
6. Refugee sponsored by the Government
7. Refugee sponsored by a group/church
8. Refugee sponsored by a relative
9. Visitor (Visitors approved are people sponsored from
 within Canada waiting for process eg. Polish
 sponsored by Polish Congress)
10. Student
11. Work Permit
12. Independent

HƯỚNG DẪN

Bảng câu hỏi về người hưởng dụng sau đây gồm có 40 câu hỏi.

Yêu cầu bạn khoanh tròn những câu trả lời thích hợp cho hoàn cảnh của bạn hoặc điền vào những chỗ để trống bằng một câu trả lời ngắn gọn.

Bạn không cần phải cho biết tên họ, TRỪ KHI bạn muốn nhận được thêm chi tiết về chương trình Kế Hoạch Hóa Gia Đình.

Xin cảm ơn sự hợp tác của bạn.

Tên họ: _____ (Tùy ý)
Số điện thoại: _____ (Tùy ý)

BẢNG CÂU HỎI VỀ NGƯỜI HƯỞNG DỤNG ĐỂ THẨM ĐỊNH CÁC NHU CẦU ĐA VĂN HÓA

XIN KHOANH TRÒN CÁC CÂU TRẢ LỜI

NAM

NỮ

Q-1 Bạn là người gốc dân nào ? _____

Q-2 Bạn sinh ở nước nào ? _____

Q-3 Bạn đã sống ở nước đó bao lâu ? _____

Q-4 Trong thời gian đó bạn sống ở nông
thôn hay thành thị ? _____

Q-5 Bạn đã sống ở đâu trước khi đến Canada ? _____

Q-6 Bạn sống ở đó bao lâu ? _____

Q-7 Bạn đến Canada từ bao giờ ? _____

Q-8 Bạn đến Hamilton từ bao giờ ? _____

Q-9 Những ngôn ngữ mà bạn nói thông thạo ? _____

Q-10 Những ngôn ngữ mà bạn đọc/viết thông thạo ? _____

Q-11 Tình trạng gia đình của bạn :

- | | |
|-----------------------------|------------|
| a. độc thân | d. ly thân |
| b. có gia đình chính thức | e. ly dị |
| c. sống chung không hôn thú | |

Q-12 Tôn giáo của bạn là gì ? _____

Q-13 Bạn có thực hành tôn giáo của mình không ?

CÓ

KHÔNG

Q-14 Bạn ở trong lớp tuổi :

- | | | | |
|----------|----------|----------|---------|
| 1. 16-25 | 2. 26-30 | 3. 31-35 | |
| 4. 36-40 | 5. 41-50 | 6. 51-64 | 7. 65 + |

Q-15 Bạn đã học xong đến lớp mấy ? _____

Q-16 Bạn làm nghề gì trước khi đến Canada ? _____

Q-17 Hiện nay bạn làm nghề gì ? _____

Q-18 Các con số nào sau đây mô tả đúng nhất tổng số lợi tức hàng năm của bạn ?

- | | |
|--------------------------|------------------------|
| a. dưới \$5.000 | b. \$6.000 đến \$9.999 |
| c. \$10.000 đến \$19.999 | d. \$20.000 đến 29.999 |
| e. \$30.000 đến \$39.999 | f. trên \$40.000 |

Q-19 Bạn có mấy con ? _____

Q-20 Bạn muốn có mấy con ? _____

Q-22 Như bạn biết, có người thực hành kiểm soát sinh đẻ có người không. Khi còn ở trong nước bạn, bạn đã có từng thực hành kiểm soát sinh đẻ không ?

CÓ KHÔNG

b. Nếu có, bạn đã dùng cách gì ? _____

Q-23 Bạn có đang thực hành kiểm soát sinh đẻ không ?

CÓ KHÔNG Nếu KHÔNG, chuyển ngay sang câu hỏi 27 và tiếp tục trả lời.

Q-24 Bạn thực hành lối kiểm soát sinh đẻ nào ? XIN KHOANH TRÒN

- | | |
|---------------------------------|---|
| a. thuốc viên ngừa thai | b. màng che tử cung |
| c. bao cao su bọc dương vật | d. kem diệt tinh trùng |
| e. vòng xoắn | f. rút dương vật ra trước khi xuất tinh |
| g. phương pháp sinh lý tự nhiên | h. bọt biển chống thụ thai |
| i. diệt khả năng sinh sản | j. cách khác _____
(Xin nói rõ) |

Q-25 Bạn có thích cách kể trên không ?

CÓ KHÔNG

Q-26 Nếu không, tại sao không _____ (Xin nói rõ)

b. Bạn có muốn thử một phương pháp khác không ?

CÓ

KHÔNG

Q-27 Nếu bạn không có thực hành kiểm soát sinh đẻ, xin cho biết tại sao không ?

a. không biết tìm ở đâu

b. muốn có thêm con

c. nghịch với tôn giáo của bạn

c. bạn có kinh nghiệm xấu về việc đó

e. bạn không cảm thấy an toàn

f. quá tốn kém

g. bạn không tin sẽ hữu hiệu

h. khó sử dụng quá

i. người phối ngẫu không muốn bạn làm

j. không thể có thai

k. bạn không có khả năng sinh lý nhiều

l. đã diệt khả năng sinh sản

Q-28 Bạn có bác sĩ mà bạn có thể đến khám dễ dàng không ?

CÓ

KHÔNG

Q-29 Nếu có, bác sĩ của bạn có nói cùng một thứ tiếng với bạn ?

CÓ

KHÔNG

Q-30 Bạn có hiểu khi bác sĩ của bạn nói chuyện với bạn không ?

CÓ

KHÔNG

Q-31 Bạn có cảm thấy thoải mái khi hỏi bác sĩ của bạn về kiểm soát sinh đẻ không ?

CÓ

KHÔNG

b. Nếu không, tại sao không ? _____ (Xin nói rõ)

Q-33 Bạn có bao giờ sử dụng một người thông dịch (một người có thể giúp bạn giải thích với những người khác bằng ngôn ngữ mà bạn không biết nói) trong bất cứ chuyện gì không ?

CÓ

KHÔNG

Q-34 Nếu bạn phải đến gặp một người nào đó để được giúp đỡ về kế hoạch hóa gia đình, bạn có cần một người thông dịch không ?

CÓ

KHÔNG

Q-35 Bạn có biết làm sao tìm người thông dịch không ?

CÓ KHÔNG

Q-36 Bạn có cảm thấy thoải mái nhờ người thông dịch để nói chuyện về kế hoạch hóa gia đình không ?

CÓ KHÔNG

Q-37 Hiện nay bạn nói chuyện về kiểm soát sinh đẻ với ai ?

- | | |
|--|--|
| a. người phối ngẫu | b. bác sĩ |
| b. cô mẹ | d. bà con |
| e. trung tâm cộng đồng của bạn | f. bạn bè |
| h. bạn không nói với ai về chuyện này cả | g. người trong nhóm tôn giáo với bạn hay cùng chỗ thờ cúng với bạn |
| i. người khác ----- | |

Q-38 Ai là người bạn cảm thấy thoải mái nhất để nói chuyện về kiểm soát sinh đẻ ?

- | | |
|--|---|
| a. bạn bè | b. bà con |
| c. người phối ngẫu | d. một người lạ |
| e. bác sĩ | f. y tá |
| g. cô mẹ | h. người đồng ngôn ngữ và văn hóa với bạn |
| i. người trong nhóm tôn giáo với bạn hay cùng chỗ thờ cúng với bạn | j. người khác ----- |

b. Trong khung cảnh nào bạn cảm thấy thoải mái để nói chuyện về kiểm soát sinh đẻ ?

- | | |
|---|---------------------------------------|
| a. tại nhà riêng của bạn | b. tại nhà cha mẹ bạn |
| c. tại nhà bà con của bạn | d. tại nhà bạn bè của bạn |
| e. tại phòng mạch bác sĩ | f. tại cơ sở về kế hoạch hóa gia đình |
| g. trong khu vực thuộc tôn giáo của bạn | h. tại một bệnh viện |
| i. tại một trung tâm cộng đồng | j. nơi khác ----- |

Q-39 Trong những điều kiện nào bạn cảm thấy thoải mái nhất để nói chuyện về kiểm soát sinh đẻ ?

- | | |
|-------------------------------|--|
| a. một mình | b. cùng với người phối ngẫu |
| c. có mặt gia đình | d. trong một nhóm gồm những người bạn quen |
| e. trong một nhóm có người lạ | |

Q-40 Tình trạng của bạn ở Canada là gì ?

1. Người đang xin quy chế tỵ nạn
2. Vào Canada bằng Giấy Phép của Bộ Trưởng (Bộ Di Trú)
3. Thường trú nhân
4. Gia đình/bà con bảo lãnh
5. Công dân Canada
6. Người tỵ nạn do chính phủ bảo trợ
7. Người tỵ nạn do hội đoàn/nhà thờ bảo trợ
8. Người tỵ nạn do thân nhân bảo trợ

မင်းလှ

အောက်ပါအတိုင်း နောက်ဆုံးအောင်မြင်မှုအတွက်
40 ရက်.

အောက်ပါအတိုင်း နောက်ဆုံးအောင်မြင်မှုအတွက်
ပုံစံပြုစု နာမည်ပေးပါ။ အောက်ပါအတိုင်း နောက်ဆုံးအောင်မြင်မှုအတွက်
ပုံစံပြုစု နာမည်ပေးပါ။

အောက်ပါအတိုင်း နောက်ဆုံးအောင်မြင်မှုအတွက်
ပုံစံပြုစု နာမည်ပေးပါ။

အောက်ပါအတိုင်း နောက်ဆုံးအောင်မြင်မှုအတွက်
ပုံစံပြုစု နာမည်ပေးပါ။

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ပုံစံပြုစု နာမည်ပေးပါ။

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ပုံစံပြုစု နာမည်ပေးပါ။

နာမဝိသေသ

ဘုရား

၁၇

မုဒုံ ၁. ခေါ်သူက ဘာလေရာကို ခေါ်လေ့ရှိသလဲ? _____

မုဒုံ ၂. ခေါ်သူက ခေါ်ရာတွင် ဥပမာ လူက? _____

မုဒုံ ၃. ဘေးကလူတို့၏ ဘုရားလေးကို ဥပမာ လူက? _____

မုဒုံ ၄. ဘုရားလေးကို (သို့မဟုတ်) ခေါ်သူက? _____

မုဒုံ ၅. ခေါ်သူက ခေါ်ရာတွင် ဘယ် ဝါဒကို ဥပမာ လူက? _____

မုဒုံ ၆. ဘေးကလူတို့၏ ဘုရားလေးကို ခေါ်သူက? _____

မုဒုံ ၇. ဘုရားကို ဥပမာ လူက? _____

မုဒုံ ၈. ဘုရားကို ခေါ်ရာတွင် ဘယ် ဝါဒကို ခေါ်သူက? _____

မုဒုံ ၉. ဘုရားကို ခေါ်ရာတွင် ဘယ် ဝါဒကို ခေါ်သူက? _____

မုဒုံ ၁၀. ဘုရားကို ခေါ်ရာတွင် ဘယ် ဝါဒကို ခေါ်သူက? _____

မုဒုံ ၁၁. ဘုရား:

a. ဘုရား

d. ဘုရား

b. ဘုရား

e. ဘုရား

c. ဘုရား ဝါဒကို ခေါ်ရာတွင် ဘယ် ဝါဒကို ခေါ်သူက?

မုဒုံ ၁၂. ခေါ်သူက ဘယ် ဝါဒကို ခေါ်သူက? _____

မုဒုံ ၁၃. ခေါ်သူက ဘယ် ဝါဒကို ခေါ်သူက? _____

မုဒုံ ၁၄. ခေါ်သူက ဘယ် ဝါဒကို ခေါ်သူက? _____

1. 16-25

2. 26-30

3. 31-35

4. 36-40

5. 41-50

6. 51-64

7. 65+

15. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

16. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

17. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

18. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

- | | |
|---------------------------|------------------------|
| a. နေပြည်တော် \$ 5,000 | b. \$ 6,000 နေ 9,999 |
| c. \$ 10,000 နေ \$ 19,999 | d. \$ 20,000 နေ 29,999 |
| e. \$ 30,000 နေ \$ 39,999 | e. နေ \$ 40,000 |

19. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

20. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

21. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

b. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

23. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

24. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

- | | |
|---------------------------------|---------------------------------|
| a. နေပြည်တော်ရှိ နေပြည်တော်အထက် | b. နေပြည်တော်ရှိ နေပြည်တော်အထက် |
| c. နေပြည်တော်ရှိ နေပြည်တော်အထက် | d. နေပြည်တော်ရှိ နေပြည်တော်အထက် |
| e. နေပြည်တော်ရှိ နေပြည်တော်အထက် | f. နေပြည်တော်ရှိ နေပြည်တော်အထက် |
| g. နေပြည်တော်ရှိ နေပြည်တော်အထက် | h. နေပြည်တော်ရှိ နေပြည်တော်အထက် |
| i. နေပြည်တော်ရှိ နေပြည်တော်အထက် | j. နေပြည်တော်ရှိ နေပြည်တော်အထက် |

25. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

26. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____ (နေပြည်တော်အထက်)

b. နေပြည်တော်ရှိ နေပြည်တော်အထက်? _____

မိုးလွင် ၇. ငြိမ်းညွှတ်ရေး အဖွဲ့ခေါင်းဆောင်များနှင့် တွေ့ဆုံရန်၊ လာကူမို့?

၆. ဖိ (သန့်ရှင်းစွာ)

၁. မြန်မာ့သမိုင်းအကျဉ်းချုပ်

विष्णु

၁. အရှင်မိမိ

j. විද්‍යා පාලන ක්‍රම (රේඛා)

l. 1785

ಸೃಷ್ಟಿ ೨೮. ಇತ್ತೀಚೆಗೆ ಡಾಕ್ಟರ್ (doctor) ಲುಕ್ಮನು ನಾಚಿಕೆಯಿಂದ ?

နမူနာ ၂၇. ဝတ်စုံကံ ကို ပြောပြပါ။ (Dance) သဘောတရားကို ချက်ချင်း ရှိသမျှ ဖော်ပြပါ။

தீச

55

30. ကျွန်ုပ်တို့၏ ကျန်းမာရေး (DOCTOR) ဒါမှမဟုတ် ကျန်းမာရေး?
 သို့သော်

57

2

ಸ್ಪಷ್ಟ. 1. ಸ್ವಲ್ಪ ಕಾಲದ ನಂತರ ಬೇರೆ ಒಂದು ದಿನ (DOCTOR) ಸಹ ಸ್ವಲ್ಪ ಕಾಲ
 ಕಾಲದ ನಂತರ ಬೇರೆ ಒಂದು ದಿನ (DOCTOR) ಸಹ ಸ್ವಲ್ಪ ಕಾಲ

ਰਾਜ

三

6. ನನ್ನ ಬಾಕಿ? _____ (ಒಮ್ಮೆ ನೋಡು)

[illegible]

వసు

۵۹

[illegible]

தேவரத்தினம் தருவதில் உறுதியுண்டா?

၆၃

65

ಸುಸ್ತುಮೇ ಎಷ್ಟುಗವಳು ನನ್ನೊಬ್ಬನು ಉಪಕರಿಸಿ ನೋಡುಗಾ ?

தரு

55

နိဗ္ဗာန် ၃၆ ကိစ္စကတော့ ၅၇၇ နှစ်လောက်ရှိတယ်လို့ဆိုတာမှန်လား? မှန်မှန်လား?

ਸੁਖ

20

နိဗ္ဗာ 37. အောက်ဖော်ပြပါများအနက်မှ မှန်ကန်သော အကြောင်းကို ခွဲခြားပါ။

a. ဥပဇ္ဈာန်

c. နှစ်

e. လောကဗျူဟာ

h. မှန်ကန်သော အကြောင်းကို ခွဲခြားပါ။

b. ခြေစုံ (DOCTOR)

d. လောကဗျူဟာ

f. ခြေစုံ

g. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

i. ခြေစုံ

နိဗ္ဗာ 38. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

a. ခြေစုံ

c. ဥပဇ္ဈာန်

e. ခြေစုံ (DOCTOR)

g. နှစ်

i. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

b. လောကဗျူဟာ

d. ခြေစုံ

f. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

h. မှန်ကန်သော အကြောင်းကို ခွဲခြားပါ။

j. ခြေစုံ

b. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

a. နှစ်

b. နှစ်

c. နှစ်

d. နှစ်

e. နှစ်

f. နှစ်

g. နှစ်

h. နှစ်

i. နှစ်

j. နှစ်

နိဗ္ဗာ 39. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

a. နှစ်

b. နှစ်

c. နှစ်

d. နှစ်

e. နှစ်

နိဗ္ဗာ 40. ဗုဒ္ဓ၏ လောကဗျူဟာကို ခွဲခြားပါ။

1. နှစ်

2. နှစ်

3. နှစ်

4. နှစ်

5. နှစ်

6. နှစ်

7. နှစ်

8. နှစ်

9. နှစ်

10. နှစ်

11. နှစ်

12. နှစ်

INSTRUÇÕES

No seguinte questionário de consumidor encontrara 40 perguntas.

Circule a resposta que melhor se adapte a sua situação, ou inscreva nos espaços em branco a resposta em breves palavras.

Não tem que dar o seu nome, a não ser que pretenda mais informações do "PLANNED PARENTHOOD" - Planejamento Familiar.

Obrigado pela sua participação.

NOME: _____ (Opcional)

Telefone # _____ (_____) _____ (Opcional)

Feminino

- 1- Qual e a sua origem etnica? _____
- 2- Qual e o seu Pais de origem? _____
- 3- Quanto tempo e que la viveu? _____
- 4- Vivia no campo ou na cidade? _____
- 5- Onde e que viveu antes de vir para o Canada? _____
- 6- Por quanto tempo e que la viveu? _____
- 7- Quando e que veio para o Canada? _____
- 8- Quando e que veio para Hamilton? _____
- 9- Que lingua(s) fala fluentemente? _____
- 10- Que lingua(s) le/escreve fluentemente? _____
- 11- Estado civil:
- | | |
|----------------|------------------|
| a. solteiro(a) | d. separado(a) |
| b. casado(a) | e. divorciado(a) |
| c. amigado(a) | |
- 12- Qual e a sua religiao? _____
- 13- Pratica presentemente a sua religiao? _____
- | | |
|-----|-----|
| SIM | NAO |
|-----|-----|
- 14- Qual e o seu grupo de idade?
- | | | |
|----------|----------|----------|
| 1. 16-25 | 2. 26-30 | 3. 31-35 |
| 4. 36-40 | 5. 41-50 | 6. 51-64 |
| 7. 65-+ | | |
- 15- Qual e o seu grau escolar? _____
- 16- Qual era a sua ocupacao antes de vir para o Canada? _____

17- Qual e a sua presente ocupacao? _____

18- Qual das seguintes categorias melhor descreve o seu rendimento anual?

- | | |
|------------------------------|------------------------------|
| a. menos de \$ 5,000.00 | b. \$ 6,000.00 a \$ 9,999.00 |
| c. \$10,000.00 a \$19,999.00 | d. \$20,000.00 a \$29,999.00 |
| e. \$30,000.00 a \$39,999.00 | f. mais de \$40,000.00 |

19- Quantos filhos tem? _____

20- Quantos filhos pretende ter? _____

21- Como sabe, algumas pessoas praticam o control de natalidade e outras nao. No seu Pais de origem alguma vez praticou o control de natalidade?

SIM

NAO

22- Se a sua resposta foi SIM, que metodo utilizou? _____

23- Actualmente pratica o control de natalidade?

SIM

NAO

-Se a sua resposta foi SIM, continue na pergunta 24

-Se a sua resposta foi NAO, passe a pergunta 27

24- Que tipo de control de natalidade utiliza?

- | | |
|---------------------------|--------------------------|
| a. Pilula | b. Diafragma |
| c. Perservativos | d. Espuma e geleia |
| e. Aparelho intra-uterino | f. Ejaculacao exterior |
| g. Planeamento familiar | h. Esponja contraceptiva |
| natural | i. Esterilizacao |
| j. Outra _____ | (Especifique) |

25- Esta satisfeito(a) com o metodo acima mencionado?

SIM

NAO

26- Se a sua resposta foi nao, porque? _____

(Especifique)

b- Gostaria de experimentar outro metodo?

SIM

NAO

27- Se actualmente nao pratica o control de natalidade, porque nao?

- | | |
|-----------------------------------|-----------------------------|
| a. Nao sabe como | b. Quer (mais) filhos |
| c. E contra a sua relegiao | d. Teve uma ma experiencia |
| e. Sente que nao e saudavel | f. Muito caro |
| g. Nao tem confianca no metodo | h. Dificil de praticar/usar |
| i. O esposo(a) nao autoriza | j. Nao consegue engravidar |
| k. Nao esta sexualmente activo(a) | l. E esteril |

28- Tem um medico(a) a quem se possa dirigir facilmente?

SIM

NAO

29- Se a sua resposta foi sim, o medico(a) fala a sua lingua?

SIM

NAO

30- Compreende o seu medico(a) quando ele(a) lhe fala?

SIM

NAO

31- Sente-se a vontade para perguntar ao seu medico(a) acerca do control de natalidade?

SIM

NAO

32- Se a sua resposta foi nao, porque? _____

(Especifique)

33- Alguma vez teve que usar um interprete para qualquer assunto de necessidade?

SIM

NAO

34- Se tivesse que se dirigir a alguem para inquirir acerca de planeamento familiar, precisaria de interprete?

SIM

NAO

35- Saberria onde procurar um interprete?

SIM

NAO

36- Sentir-se-ia a vontade utilizar um interprete para falar de planeamento familiar?

SIM

NAO

37- Actualmente com quem fala acerca do control de natalidade?

- | | |
|---|---|
| a. Esposo(a) | b. Medico(a) |
| c. Parteira | d. Relativos |
| e. O seu centro comunitario | f. Amigos |
| g. Alguem do seu grupo religioso, ou lugar de culto | h. Nao fala com ninguem acerca do assunto |
| i. Outro _____ | |

38- Com quem se sentiria mais a vontade falar acerca do control de natalidade?

- | | |
|---|--|
| a. Amigos | b. Relativos |
| c. Esposo(a) | d. Um estranho |
| e. Medico(a) | f. Enfermeiro(a) |
| g. Parteira | h. Alguem que conheca a lingua e cultura |
| i. Alguem do seu grupo religioso, ou lugar de culto | |
| j. Outro _____ | |

b- Em que ambiente se sentiria mais a vontade para falar de control de natalidade?

- | | |
|--------------------------------|---|
| a. Em sua casa | b. Em casa de seus pais |
| c. Em casa de relativos | d. Em casa de amigos |
| e. No consultorio do medico(a) | f. Numa clinica de planeamento familiar |
| g. Em ambiente religioso | i. Num centro comunitario |
| h. Num hospital | |
| j. Outro _____ | |

39- Em que condicoes se sentiria mais a vontade para falar de control de natalidade?

- | | |
|-------------------------------|---------------------------------|
| a. A sos | b. Entre o casal |
| c. Em familia | d. Em grupo com gente conhecida |
| e. Em grupo com desconhecidos | |

40- Qual e o seu estatuto no Canada?

1. Refugiado
2. Autorizacao do ministerio da emigracao
3. Residente permanente
4. Sob proteccao de familiares
5. Cidadao Canadiano
6. Refugiado sob proteccao governamental
7. Refugiado sob proteccao de algum grupo/Igreja
8. Refugiado sob proteccao de um familiar
9. Turista
10. Estudante
11. Autorizacao de trabalho
12. Independente

INSTRUCTIONS:

In the following consumer questionnaire you will find 40 questions. 下列問卷有四十條問題

You need to either circle the answer which applies to your situation, or fill in the blanks, with a short answer. 回答時只需每題圈出答案或填上簡短答案

You do not need to leave your name, UNLESS you want additional information from Planned Parenthood. 你不必填寫姓名除非你想
要獲得更多資料

Thank-you for your participation. 謝謝你的參與

Name: _____ (optional)

Phone #: _____ (optional)

MULTICULTURAL NEEDS ASSESSMENT
CONSUMER QUESTIONNAIRE

CIRCLE THE ANSWER 圈答其中一項

MALE 男

FEMALE 女

Q-1 你的國籍
What is your Ethnic Origin? _____

Q-2 出生國家
What country were you born in? _____

Q-3 在當地居住多久
How long did you live there? _____

Q-4 你曾在當地居住
Did you live in the country or the city? _____

Q-5 來加之前你,在何處居住
Where did you live before you came to Canada? _____

Q-6 在當地住了多久
How long did you live there? _____

Q-7 何時來加
When did you come to Canada? _____

Q-8 何時來活明頓
When did you come to Hamilton? _____

Q-9 何種語言你能流利的交談
What language(s) do you speak, fluently? _____

Q-10 何種語言你能書寫與閱讀
What language(s) do you read/write, fluently? _____

Q-11 Are you: 你是

a. single 單身

d. separated 分居

b. married 結婚

e. divorced 離婚

c. common-law 同居

Q-12 你的宗教信仰
What is your religion? _____

Q-13 你是否在進行你的信仰?
Are you currently practicing your religion? _____

YES

NO

Q-14 What is your age range? 你的年齡

1. 16-25

2. 26-30

3. 31-35

4. 36-40

5. 41-50

6. 51-64

7. 65 +

你的學歷

Q-15 What level of schooling did you complete? _____

來加前的職業

Q-16 What was your occupation before coming to Canada? _____

現在的職業

Q-17 What is your occupation now? _____

Q-18 Which of the following categories best describes your total annual income? 年薪

- | | |
|-------------------------|-------------------------|
| a. less than \$5,000 | b. \$6,000 to \$9,999 |
| c. \$10,000 to \$19,999 | d. \$20,000 to \$29,999 |
| e. \$30,000 to \$39,999 | e. over \$40,000 |

你有多少孩子

Q-19 How many children do you have? _____

你還有多少孩子

Q-20 How many children do you want to have? _____

Q-22 As you know, some people practice birth control and some people do not. Did you practice birth control in your country of origin? 有些人練習有些人沒有? 在他們的國家中有没有節育的習俗

YES

NO

如有, 你用何種方法

b. If yes, what did you use? _____

Q-23 Do you practice birth control now? 你現在有没有實行節育

YES

NO

If NO, go to QUESTION 27 and continue (如沒有, 由27題開始回答)

請圈出所用節育方法

Q-24 What type of "birth control"? PLEASE CIRCLE

- | | |
|-----------------------------------|----------------------------|
| a. birth control pills 藥丸 避孕丸 | b. diaphragm 子宮帽與子宮帽 |
| c. condom 避孕套 | d. foams and jellies |
| e. IUD 子宮環 | f. withdrawal |
| g. Natural Family Planning 自然家庭計劃 | h. contraceptive sponge 海棉 |
| i. sterilization 動手術 | j. other _____ (specify) |

Q-25 Are you happy with the above type? 對所用的方式是否滿意

YES

NO

如否, 是什么原因

Q-26 If no, why not? _____ (specify)

b. Would you like to try another method? 你願不嘗試其他方式

YES

NO

你為何沒有用節育的方法

Q-27 If you are not practicing birth control, why not?

- a. don't know where to get any ^{不知從何得知}
b. want (more) children ^{想多些孩子}
c. it is against your religion ^{宗教不容許}
d. you had a bad experience ^{壞經驗}
e. you don't feel it's physically safe ^{對身體健康有危害}
f. too expensive ^{太貴}
g. you don't trust it will work ^{不信它是有效}
h. too hard to use ^{太難使用}
i. spouse doesn't want you to ^{配偶不希望你用}
j. cannot get pregnant ^{不能懷孕}
k. not sexually active ^{沒有性行為}
l. sterilization ^{動了手術}

Q-28 Do you have a doctor you can easily call?
^{你是否有一位醫生可輕易找你}

YES

NO

Q-29 If yes, does your doctor speak the same language you do?
^{你的醫生是說你相同的語言}

YES

NO

Q-30 Do you understand your doctor when he/she speaks to you?
^{你能明白你醫生所說的嗎?}

YES

NO

Q-31 Would you feel comfortable to ask your doctor about birth control?
^{你能否坦然的向你醫生詢問有關節育的事?}

YES

NO

b. If no, why not? _____ (specify)
^{如否, 是何原因}

Q-33 Have you ever used an interpreter (someone to help you explain to others in the language you cannot speak) for anything?
^{你是否需要別人為你翻譯}

YES

NO

Q-34 If you were to go to someone for help with family planning would you need an interpreter?
^{假如你去別人有家庭計劃之事, 你是否需要人翻譯}

YES

NO

Q-35 Would you know where to get an interpreter?
^{你知道如何可以找一位他翻譯員嗎?}

YES

NO

Q-36 Would you feel comfortable using an interpreter to talk about family planning?
^{如用他翻譯員來談及家庭計劃之事, 你是否}

YES

NO ^{不覺不自然}

現今你向誰談及生育的問題

Q-37 Who do you talk to about birth control now?

- a. spouse 配偶
- b. doctor 醫生
- c. midwife 接生婦
- d. relatives 親屬
- e. your community 社區中心
- f. friends 朋友
- g. someone from your religious 教會人士
- h. you don't talk to anyone about it
- i. other 其他
- j. other 其他

Q-38 Who would you feel most comfortable talking to about birth control? 你覺得向誰談及生育之事會最自然?

- a. friends 朋友
- b. relative 親屬
- c. spouse 配偶
- d. a stranger 陌生人
- e. doctor 醫生
- f. nurse 護士
- g. midwife 接生婦
- h. someone who knows your language and culture 明白你的文化背景及語言者
- i. someone from your religious group or place of worship 教會人士
- j. other 其他

b. In what setting would you feel most comfortable in to talk about birth control? 在何環境下你會覺得最自然來談及生育的問題

在住宅中
在親屬家中
診所
教會
社區中心

- a. in your own home
- b. in your parents home 父母家中
- c. in your relatives home
- d. in your friends home 朋友家中
- e. in a doctors office
- f. in a family planning clinic 家庭計劃中心
- g. in religious surroundings
- h. in a hospital 醫院
- i. in a community centre
- j. other 其他

Q-39 Under what conditions would you be most comfortable to talk about birth control? 在何情況下你會覺得最自然來談及生育之事

- a. alone 單獨
- b. as a couple 夫婦一同
- c. as a family 整個家庭
- d. in a group with people you know 與相識的人在一起
- e. in a group with strangers 與陌生人

Q-40 What is your status in Canada? 在加拿大的身份

1. Refugee Claimant 難民
2. Minister's Permit (Ministry of Immigration) 領事
3. Landed Immigrant? Permanent Resident 移民
4. Family class/ Assisted Relative 家人申請
5. Citizen 公民
6. Refugee sponsored by the Government 政府申請難民
7. Refugee sponsored by a group/church 教會(團體)申請難民
8. Refugee sponsored by a relative 親友申請難民
9. Visitor (Visitors approved are people sponsored from abroad within Canada waiting for process eg. Polish sponsored by Polish Congress)
10. Student 學生
11. Work Permit 工作證
12. Independent 獨立移民

Koobaabin geli Jawaabla.

LAB (Ragga)

DHELS G (dumar)

- S-1 Maxey tahay Jinsiyaddadu? _____
- S-2 Waddanke baad ku di dalalay? _____
- S-3 Immisa (meego) ayaad ku nooleyd waddanka? _____
- S-4 Ma miyiga (Baadijo) ayaad ku nooleyd mise magaalo? _____
- S-5 Halkee baad ku nooleyd inta aadan iman Kanada? _____
- S-6 Immise (meego) ayaad ku nooleyd Halkeasi? _____
- S-7 Goorma ayaad timid Kanada? _____
- S-8 Goorma ayaad timid Hamilton? _____
- S-9 Lugaddee (Lugadahee) ayaad ku hadashaa si fiican? _____
- S-10 Lugaddee (Lugadahee) ayaad Akhrisaa/Qortaa si fiican? _____
- S-11- Ma Waxaad tahay:
- a) gof aan guursan ama hadda aan gabin
 - b) Xas leh
 - c) Wada nool laakiin aan isgabin
 - d) Guursadey (gabo xas) laakiin kala nool
 - e) Kala tagey (Furiin)
- S-12- Maxey tahay diintaadu? _____
- S-13- Hadda ma ku dhagantaa diintaada?
- HAA MAYA
- S-14 Inteebey da'daada u dhaxeysaa?
- | | | |
|----------|----------|----------|
| 1. 16-25 | 2. 26-30 | 3. 31-35 |
| 4. 36-40 | 5. 41-50 | 6. 51-64 |
| | | 7. 65+ |
- S-15 ilaa iyo heerkee baad ka gaartay Waxbarasho? _____
- S-16 Maxey aheyd shagadaada inta aad iman Kanada? _____
- S-17 Maxey tahay shagadaada hadda? _____
- S-18 Qeybaha Soo Socda tee baa si fiican u sharaxeysa dhagaalaha ku soo gala Sannadkii
- | | |
|---------------------------|-------------------------|
| a) in ka yar \$5,000 | b) \$6,000 ilaa \$9,999 |
| c) \$10,000 ilaa \$19,999 | d) \$20,000 ilaa 29,999 |
| e) \$30,000 ilaa 39,999 | f) in ka badan \$40,000 |

S-19. Immisa (meego) Carruur ayaad leedahay? _____

S-20 - Immisa (meego) Carruur ayaad jeceshahay in and yeelato? _____

S-22a) Sidee aad ogtahayba, dadka gaarkii waxey isticmaalaan ama ku dhagmaan Waxyaabo lagu joojiyo dhalmada dadka gaarkusna ma isticmaalaan. Adiga ma ku dhagme jirto intii aad joogtay Waddanka aad u dhacday?

HAA

MAYA

b) Haddii Jawaabtaadu tahay Haa, Maxaad isticmaali jirtey?

S-23. Hadda ma ku dhagantaa (Isticmaashaa) Waxa Lagu joojiyo dhalmada (uurka)?

HAA

MAYA

Haddii Maya Aad Siiasha 27aad Siina Wad.

S-24 Habkee (Nooc) baad isticmaashaa hakinta dhalmada (uurka)?
Fadalan Koobaabin geli.

a) Kaniiniga hakinta dhalmada

b) in la daboolo Ama Lagu joojiyo naafta Xubnaheeda ay u maraan biyaha

c) Baniiro ay ragga u gashadaan hakinta uun gaadista iyo kahortagga cudurada Farfa.

d) Xubso ku daboolan Baniiro oo ay dumarka isticmaalaan si loo joojiyo gaadista uurka.

e) Faraati lagu xiro ilmogaleenka si loo joojiyo gaadista uurka.

f) Ka soo Saaridda Unugga ragga si ay biyaha (sperm) ugu daataan dibeda.

g) Habeynt dabiiciga ah ee qorsheha qoyska.

h) Isbuunyo ay gashadaan dumarka si ay joojiyaan gaadista uurka.

i) Awood ka Saaridda Samaynta ukunta.

j) Kuwo kale _____ Sharax (Qeex).

S-25 Ma ku faraxsan tahay nooca Aad Kor ku Sheegtay?

HAA

MAYA

S-26a Haddii Maya, Maxaad ugu faraxsaneyn? _____ Sharax (Qeex)

S-26b Ma jeceshahay in aad isku daydo nooc kale?

HAA

MAYA

S-27 - Maxaad u isticmaalin hakinta dhalmada (uurka)?

a) ma garanayo meel lagu helo.

b) Waxaan doondiyaa Carruur badan

c) Waxey ka soo horjeeddaa diintaada

- d) Waxaad ka dhaxashay (Kala Kulantay) Waayo Qaahimo Xun.
- e) Uma dareensanid in u wanaagsantahay Jir (Kor) ahaan.
- f) Aad ayey gaadhi u tahay.
- g) Ma rumeynid (Aaminsanid) in ay shageyn doonto.
- h) Aad bay u adag tahay sida loo isticmaalo.
- i) Qofka aad isgabatay (Xaaska) ma doonayo.
- j) Uur ma yeelan Kartid.
- k) Ma Kacsado.
- l) Awood ka baariidla Sameynta Ukunta.

S-28. Ma Leedahay takhtar aad si sahlan ku arki Kartid?

HAA MAYA

S-29 Haddii Haa, takhtarkaada ma ku hadlaa lugaddaada?

HAA MAYA

S-30 Ma fahantaa Marka takhtarkaadu kula hadlo/hadasho?

HAA MAYA

S-31 Ma ka xishootaa in aad weydiiiso takhtarkaaga Suuqo ku saabsan hakinta olhelmade.

HAA MAYA

S-31b. Haddii Haa Maxaa Jira? _____

S-33 Weligaa ma u isticmaashay Qof in uu kaaga turjumo (Warceliyo) Lugad aadan garaneyn Wax walba ee ahaatee?

HAA MAYA

S-34 Haddii aad aadeyso gof ka caawinta habeynta qorsaha Qoyska (Family planning) ma u barhaneysaa Turjubaan?

HAA MAYA

S-35 Ma tayaannaa (ogtahay) meel laga kelo turjubaan?

HAA MAYA

S-36 Ma ka xishoneysaa in turjubaan kula joogo Marka aad ka hadleyso habeynta qorsaha Qoyska?

HAA MAYA

S-37. Ayaad kala hadashaa hakinta dhalmaada hadda?

- a) Qofka aan isgabno
- b) takhtarka
- c) Umuliso
- d) Qaraabo
- e) Xarunta Ururka (Community)
- f) Saaxiibbo
- g) Cid aad kala hadashaa Magfurto
- h) Qoboyin diintaada ah.
- i) Kuwo Kale _____

S-38.A) Ayaad Jeceshahay inta badan in aad kala hadashid hakinta dhalmaada?

- a) Saaxiibbo
- b) Qaraabo
- c) Qofka aan is gabno
- d) Qof aynaan is aqoon
- e) takhtar
- f) Kakaaliyaha takhtarka
- g) umuliso
- h) Qof Lugaddaada yaqaan
- i) Qof ka socda diintaada
- j) Kuwo Kale _____

S-38B Halkood Jeceshay ama aad ku kalsoontahay in aad joogto Marke aad ka hadleyso hakinta dhalmaada?

- a) gurigaada
- b) guriga Waalidkaa
- c) guriga Qaraabadaa
- d) guriga Saaxiibadaa
- e) Xafiiska takhtarka
- f) Rugta (Xarunta) habeynta Qowshaha Qoyska
- g) meel diineed
- h) Isbitaal
- i) Xarunta Kumunitiga
- j) meel Kale _____

S-39 Xaladda ayaad jeceshahay in aad kaga hadasho hakinta dhalmaada?

- a) Keli
- b) Anniqoo Lamaanan (nin iyo naagtiis)
- c) Qoys ahaan
- d) Koox dad aad taqaanid
- e) Koox dad aadan aqoon.

S-40 Waa maxey Xaaladdada Kanada ?

1. Weydiistey Qaxootinnimo.
2. Ogolaansho Wasaradda Socodka.
3. Soo galoti degaasho leh (Landed)
4. Sabagad Qoys / Caawinaam Qaraabo
5. Dhalasho
6. Qaxooti ay dammaanatay dowladda
7. Qaxooti ay dammaanatay Koox / Kaniisad
8. Qaxooti ay dammaantay Qaraabo.
9. Siyaaro (Boqasho) (Boqashade Waxaa ogolaaday dad
Laga dammaantay ujoos Kanada Joopo oo Sugaya
inta ay ka dhammaato Shigade Warqadooda
tusale: Polish ay dammiinteen Golaha polishka)
10. Ardey
11. Ogolaansho Shago :
12. Qof aan Meel ku tiirsaneyn.

INSTRUCCIONES:

En el siguiente cuestionario del consumidor Ud. encontrará 40 preguntas.

Ud. debe hacer un círculo a la respuesta que aplique a su situación, o llenar los espacios en blanco con una respuesta corta.

No necesita poner su nombre, A NO SER que Ud. requiera información adicional de Planificación Familiar.

Gracias por su cooperación.

Nombre: _____ (opcional)

Teléfono #: _____ (opcional)

EVALUACION DE NECESIDADES MULTICULTURALES
Cuestionario del Consumidor

Haga un círculo a la respuesta

MASCULINO

FEMENINO

P-1 Cuál es su Origen Etnico? _____

P-2 En qué país nació? _____

P-3 Qué tiempo vivió allí? _____

P-4 Vivio Ud. en el campo o en la ciudad? _____

P-5 Dónde vivió antes de venir a Canada? _____

P-6 Por cuanto tiempo vivió allí? _____

P-7 Cuándo llegó a Canada? _____

P-8 Cuándo vino a Hamilton? _____

P-9 Qué idioma (s) habla, fluidamente? _____

P-10 Qué idioma (s) lee/escribe, fluidamente? _____

P-11 Es Ud.:

- a. Soltero (a)
- b. Casado (a)
- c. Acompañado (a)

- d. separado (a)
- e. divorciado (a)

P-12 Cuál es su religión? _____

P-13 Esta Ud. practicando su religión actualmente? _____

SI

NO

P-14 Entre que edades está Ud.?

- | | | | |
|----------|----------|----------|---------|
| 1. 16-25 | 2. 26-30 | 3. 31-35 | 7. 65 + |
| 4. 36-40 | 5. 41-50 | 6. 51-64 | |

P-15 Qué grado de educación completo? _____

P-16 Cuál era su ocupación antes de venir a Canada? _____

P-17 Cuál es su ocupación ahora? _____

P-18 Cuál de las siguientes categorías describe mejor sus ingresos anuales?

- | | |
|---------------------------|---------------------------|
| a. menos de \$5,000 | b. de \$6,000 a \$9,999 |
| c. de \$10,000 a \$19,999 | d. de \$20,000 a \$29,999 |
| e. de \$30,000 a \$39,999 | f. más de \$40,000 |

P-19 Cuántos niños tiene? _____

P-20 Cuántos niños quiere tener? _____

P-22 Como Ud. sabe, algunas personas practican el control de la natalidad y otras personas no la practican. Practicaba el control de la natalidad en su país de origen?

SI

NO

b. Si su respuesta es afirmativa, qué usaba? _____

P-23 Practica el control de la natalidad ahora?

SI

NO Si la respuesta es negativa, vaya a la pregunta numero 27 y continúe.

P-24 Qué tipo de control de natalidad usa? POR FAVOR MARQUE CON UN CÍRCULO

- | | |
|-----------------------------------|--------------------------------|
| a. píldoras anticonceptivas | b. diafragma |
| c. condón | d. espumas y lubricantes |
| e. dispositivo intrauterino | f. el coito interrumpido |
| g. planificación familiar natural | h. esponja contraceptiva |
| i. esterilización | j. otro _____
(especifique) |

P-25 Está Ud. contenta con el tipo de contracepción mencionado arriba?

SI

NO

P-26 Si la respuesta es negativa, por que nó? _____
(especifique)

b. Le gustaría probar otro método?

SI

NO

P-27 Si Ud. no está practicando el control de natalidad, diga por que nó?

- | | |
|---|-----------------------------------|
| a. no sabe donde obtener información | b. quiere (más) niños |
| c. va esto en contra de su religión | d. ha tenido Ud. mala experiencia |
| e. Ud. piensa que le puede hacer daño físicamente | f. demasiado caro |
| | h. muy difícil para usarlo |
| g. no confía que vaya a tener buen resultado | j. no puede quedar embarazada |
| i. el esposo (a) no quiere que lo use | l. esterilización |
| k. no esta sexualmente activa | |

P-28 Tiene Ud. un doctor que puede llamarlo con facilidad?

SI NO

P-29 Si su respuesta es afirmativa, diga si su doctor habla el mismo idioma que Ud?

SI NO

P-30 Comprende Ud. a su doctor cuando él o ella le habla?

SI NO

P-31 Tiene Ud. suficiente confianza en su doctor para hablar de contracepción?

SI NO

b. Si la respuesta es negativa, diga por que nó _____
(especifique)

P-33 Alguna vez Ud. ha necesitado los servicios de un interprete (alguien quien le ayude explicar a otros en el idioma que Ud. no puede hablar) en alguna ocasión?

SI NO

P-34 Si Ud. tuviera que pedir ayuda en asuntos de planificación familiar, necesitaría intérprete?

SI NO

P-35 Sabría Ud. dónde localizar un intérprete?

SI

NO

P-36 Se sentiría Ud. cómodo (a) usando un intérprete para hablar de planificación familiar?

SI

SI

P-37 Con quién discute Ud. acerca del control de la natalidad ahora?

- | | |
|---|---------------|
| a. esposo (a) | b. doctor |
| c. partera | d. parientes |
| e. su centro comunitario | f. amigos |
| g. alguien de su grupo religioso o lugar de oración | |
| h. ud. no habla a nadie acerca de este tema | i. otro _____ |

P-38 Con quién se sentiría Ud. más cómodo (a) hablar del control de la natalidad?

- | | |
|---|--|
| a. amigos | b. parientes |
| c. esposo (a) | d. un desconocido |
| e. doctor | f. enfermera |
| g. partera | h. alguien quien sabe de su idioma y cultura |
| i. alguien de su grupo religioso o lugar de oración | j. otro _____ |

b. En que escenario se sentiría Ud. más cómodo (a) para hablar del control de la natalidad?

- | | |
|--------------------------------|--|
| a. en su propia casa | b. en la casa de sus padres |
| c. en la casa de sus parientes | d. en la casa de sus amigos |
| e. en la oficina del doctor | f. en la clínica de planificación familiar |
| g. en un ambiente religioso | h. en el hospital |
| i. en un centro comunitario | j. otro _____ |

P-39 Bajo que condiciones se sentiría Ud. más cómodo (a) para hablar del control de la natalidad?

- a. sólo (a)
- b. como pareja
- c. como familia
- d. en un grupo de personas conocidas
- e. en un grupo de desconocidos

P-40Cuál es su status en Canada?

1. Reclamante de Refugio
2. Permiso Ministerial (Ministerio de Inmigración)
3. Residente Permanente
4. Clase familiar/ Recibe ayuda de un pariente
5. Ciudadano
6. Refugiado patrocinado por el gobierno
7. Refugiado patrocinado por un grupo/iglesia
8. Refugiado patrocinado por un pariente
9. Visitante (Los visitante aprobados son personas patrocinadas dentro de Canada y que estan esperando ser procesados ej. Un Polaco patrocinado por el Congreso Polaco)
10. Estudiante
11. Permiso de trabajo
12. Independiente

Planned Parenthood Society of Hamilton

April 12, 1944

Dear Sir:

Thank you for your letter of March 28, 1944, and for the information you have given in relation to the above named subject.

The Planned Parenthood Society of Hamilton, is a non-profit organization, and is not a religious institution.

APPENDIX D—AGENCY INTRODUCTION LETTER AND SURVEY:

It is the purpose of this study to determine the extent of the use of birth control in the Hamilton area. It is hoped that the results of this study will be of value to the community in general, and to the health department in particular. It is also hoped that the results of this study will be of value to the health department in the planning of its birth control program. It is hoped that the results of this study will be of value to the health department in the planning of its birth control program.

The results of this study will be made available to the Board of Supervisors for their consideration. It is hoped that the results of this study will be of value to the health department in the planning of its birth control program.

If there are any questions regarding the above, please do not hesitate to contact me at 725-1211.

Thank you for your assistance.

Sincerely,

Yours faithfully,

Yvonne Desjardins

Birth Control Social Assessment Project Coordinator



Planned Parenthood Society of Hamilton

July 12, 1991

Dear:

Recent studies have addressed issues concerning Hamilton's racially and culturally diverse groups in relation to health care and accessibility to service.

The Planned Parenthood Society of Hamilton is currently undertaking a study to determine whether or not a need exists for family planning services in our community's racially and culturally diverse groups. More specifically, the assessment will look at how the socio-economic, cultural, and religious factors affect family planning decisions.

It would be too costly to ask for the opinions of every worker in each agency in the community. Your name has been selected for this purpose and it is very important that you are able to complete the questionnaire. Because of the limited time frame of this study I will be picking up the completed questionnaires in two to three weeks time. A phone call will be made prior to this time to ensure the completion of the information.

Your answers, collectively, with other agency personnel, will compose one part of this multicultural needs assessment. In this way, your confidentiality will be maintained.

The results of this study will be made available to the Board of Directors for service delivery considerations. It will also be made available to agencies upon request.

If there are any questions regarding the above, please do not hesitate to contact me at 529-5548.

Thank-you for your assistance.

Sincerely,

Thecla Damianakis
Multicultural Needs Assessment Project Coordinator



Planned Parenthood Society of Hamilton

MULTICULTURAL NEEDS ASSESSMENT

AGENCY QUESTIONNAIRE

MULTICULTURAL NEEDS ASSESSMENT
AGENCY QUESTIONNAIRE

1. Are you an ethnospecific (ie. agency/organization which serves one or more ethnocultural groups primarily, although would serve others as well) or a generic agency (ie. serve the general population according to agency mandate)?

2. Does your agency service racially and/or culturally diverse persons (fe. immigrants and/or refugees)?

YES _____ NO _____

2b. If yes, in what capacity?

3. Does your agency service racially and/or culturally diverse women regarding reproduction/family planning? (ie. issues affecting ones decision to have or not to have children) (See examples in Question 4)

YES _____ NO _____

4. If yes, please circle reason for service, and rate from the most (score 10) to the least (score 1) requested:

- a. _____ wants information on accessing health services for women eg.clinic
- b. _____ information on birth control methods
- c. _____ infertility
- d. _____ social and economic circumstances in relation to sexuality and reproductive life
- e. _____ concerns with child rearing
- f. _____ conflict with their cultural/religious background and social norms in the areas of abortion; fertility; new reproductive technology?
- g. _____ wants information/options about an unwanted pregnancy
- h. _____ diagnosis/treatment of sexually transmitted diseases
- i. _____ other _____ (specify)

MULTICULTURAL NEEDS ASSESSMENT AGENCY QUESTIONNAIRE

1. Are you an ethnospacific (ie. agency/organization which serves one or more ethnic/cultural groups primarily, although would serve others as well) or a generic agency (ie. serve the general population according to agency mandate)?

2. Does your agency service racially and/or culturally diverse persons (ie. immigrants and/or refugees)?

YES _____ NO _____

2b. If yes, in what capacity?

3. Does your agency service racially and/or culturally diverse women regarding reproduction/family planning? (ie. issues affecting ones decision to have or not to have children) (See examples in Question 4)

YES _____ NO _____

4. If yes, please circle reason for service, and rate from the most (score 10) to the least (score 1) requested:

- a. _____ wants information on accessing health services for women eg. clinic
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- d. _____ social and economic circumstances in relation to sexuality and reproductive life
- e. _____ concerns with child rearing
- f. _____ conflict with their cultural/religious background and social norms in the areas of abortion; fertility; new reproductive technology?
- g. _____ wants information/options about an unwanted pregnancy
- h. _____ diagnosis/treatment of sexually transmitted diseases
- i. _____ other _____ (specify)

5. How many women, on average, would you provide service to in a month, for the concerns in question four?

a. _____
b. _____
c. _____
d. _____

e. _____
f. _____
g. _____
h. _____

6. How many women, on average, would you refer elsewhere in a month, for the concerns in question four, and to where?

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____
g. _____
h. _____

7. Part of this study will involve focus groups of specific racially and/or culturally diverse groups, to determine "self-need".

Which groups would you recommend be targeted for this purpose because you think they are most in need of family planning?

Please list in order of priority the specific racially and/or culturally diverse groups; their place of origin ie. rural or urban location; their religion; your reason for identifying these ethnic groups; and whether there is a contact person and number for that group.

Ethnic Group	Location	Religion	Reason	Contact
	rural/urban		for choice	

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

5. How many women, on average, would you provide service to in a month, for the concerns in question four?

a.	_____
b.	_____
c.	_____
d.	_____
e.	_____

6. How many women, on average, would you refer elsewhere in a month, for the concerns in question four, and to where?

a.	_____
b.	_____
c.	_____
d.	_____
e.	_____
f.	_____
g.	_____
h.	_____

7. Part of this study will involve focus groups of specific racially and/or culturally diverse groups, to determine "self-need".

Which groups would you recommend be targeted for this purpose because you think they are most in need of family planning? Please list in order of priority the specific racially and/or culturally diverse groups; their place of origin; rural or urban location; their religion; your reason for identifying these ethnic groups; and whether there is a contact person and number for that group.

Ethnic Group	Location	Religion	Reason	Contact
	rural/urban		for choice	

a.	_____
b.	_____
c.	_____
d.	_____
e.	_____
f.	_____

8. Please comment on any significant beliefs/values regarding your identified ethnic groups and family planning.

9. List any barriers you feel exist for your identified ethnic groups, in their ability to access information or receive assistance from programs, organizations, medical services etc. regarding family planning.

10. Where do you think individuals within your identified groups would go/do go for assistance in the community to address their concerns and obtain information regarding family planning? Would there be/are there problems with these sources?

11. Do you feel there is a need for racially and/or culturally diverse women to have greater access to and information no reproductive/family planning services, (ie. counselling, educational sessions, medical examinations, contraceptive devices) in the Hamilton community?

YES _____

NO _____

If yes, why?

8. Please comment on any significant beliefs/values regarding your identified ethnic groups and family planning.

9. List any barriers you feel exist for your identified ethnic groups, in their ability to access information or receive assistance from programs, organizations, medical services etc. regarding family planning.

10. Where do you think individuals within your identified groups would go/do go for assistance in the community to address their concerns and obtain information regarding family planning? Would there be/are there problems with these sources?

11. Do you feel there is a need for racially and/or culturally diverse women to have greater access to and information on reproductive/family planning services, (i.e. counseling, educational sessions, medical examinations, contraceptive devices) in the Hamilton community?

If yes, why?

NO

If no, why not?

12. What do you believe would be the most effective way of meeting the needs for your identified groups?

Ethnic Group	Need	Way to Meet Need
--------------	------	------------------

13. Do you facilitate and/or are involved with any groups/individuals from racially and/or culturally diverse backgrounds, who might agree to meet with me?

YES _____

NO _____

If yes, would you be willing to set up a meeting time for this purpose?

YES _____

NO _____

14. Is there any additional information or suggestions which might help Planned Parenthood's ability to meet the needs of Hamilton's diverse racial and cultural communities?

Agency Name: _____

Name of person who completed questionnaire: _____

Brief comment on agency's role: _____

Date: _____

THANK-YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.

THANK-YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.

Date: _____

Brief comment on agency's role: _____

Name of person who completed questionnaire: _____
Agency Name: _____

14. Is there any additional information or suggestions which might help Planned Parenthood's ability to meet the needs of Hamilton's diverse racial and cultural communities?

YES _____

NO _____

If yes, would you be willing to set up a meeting time for this purpose?

YES _____

NO _____

13. Do you facilitate and/or are involved with any groups/individuals from racially and/or culturally diverse backgrounds, who might agree to meet with me?

Ethnic Group _____
Need _____
Way to Meet Need _____

12. What do you believe would be the most effective way of meeting the needs for your identified groups?

If not, why not? _____

APPENDIX E—PILOT FOCUS GROUP QUESTIONS:

PILOT FOCUS GROUP DISCUSSION QUESTIONS

Introduction and Purpose

1. Tell me about birth control and family planning in your country of origin.
2. Explain any positive and/or any negative experiences you remember about family planning and birth control.
3. Is there anything that surprises you about birth control in Canada?
4. If your good friend tells you that her husband wants to have more children but she does not want to, what would you say to your friend? How would you help her?
5. If Planned Parenthood could develop a service with members of your ethnic community, what do you think would be needed if anything, and what would be the best way to make contact?

APPENDIX F—FOCUS GROUP AGENDA:

PLANNED PARENTHOOD SOCIETY OF HAMILTON

MULTICULTURAL NEEDS ASSESSMENT

FOCUS GROUP AGENDA

DATE AND TIME OF FOCUS GROUP

NAME OF FOCUS GROUP

1. Introduction of Self/Rounds/overview of project

- * purpose of project
- * importance of women's input
- * ground rules: respect for each others views even if don't agree
- * confidentiality issues/consent form signing
- * what is birth control/family planning (factors affecting ones decisions to have or not have children)

2. Completion of Questionnaire

3. Questions for discussion:

a. Explain birth control and family planning in:

- * your country of origin;
- * in Canada
- * city versus country influences

b. Values clarification: What do you think about...

- * children (purpose of)
- * sex of children
- * family size (ideal)
- * family roles (what are they) (includes extended family)
- * marital status and sexuality/reproduction
- * having or not having much money and having children
- * the pill
- * the IUD
- * the condom
- * natural family planning (rhythm; withdrawal)
- * sterilization
- * diaphragm
- * abortion
- * raising children
- * infertility
- * whose responsibility is it to plan the number of children wanted
- * whose responsibility is it to prevent (more) children
- * STD/AIDS

PLANNED PARENTHOOD SOCIETY OF HAMILTON

MULTICULTURAL NEEDS ASSESSMENT

FOCUS GROUP AGENDA

DATE AND TIME OF FOCUS GROUP

NAME OF FOCUS GROUP

1. Introduction of Self/Rounds/Overview of project
 - * purpose of project
 - * importance of women's input
 - * ground rules: respect for each others views even if don't agree
 - * confidentiality issues/consent form signing
 - * what is birth control/family planning (factors affecting ones decisions to have or not have children)
2. Completion of Questionnaire
3. Questions for discussion:
 - a. Explain birth control and family planning in:
 - * your country of origin;
 - * in Canada
 - * city versus country influences
 - b. Values clarification: What do you think about...
 - * children (purpose of)
 - * sex of children
 - * family size (ideal)
 - * family roles (what are they) (includes extended family)
 - * marital status and sexual/reproduction
 - * having or not having much money and having children
 - * the pill
 - * the IUD
 - * the condom
 - * natural family planning (rhythm; withdrawal)
 - * sterilization
 - * diaphragm
 - * abortion
 - * raising children
 - * infertility
 - * whose responsibility is it to plan the number of children wanted
 - * whose responsibility is it to prevent (more) children
 - * STD/AIDS

- * what your religion/faith tells you about birth control/family planning
- * the medical system here (responsiveness and flexibility of eg. accessibility to service etc.)

4. What are your needs regarding family planning?

accessibility: transportation, translation, costs, cultural sensitivity, what types of birth control most appropriate etc.

5. Suggestions for change: What should P.P. do?

a)LIST:

*short term goals

*long term goals

6. Conclusions and Feedback

*how did that feel?

*would the group be willing to meet again to go over the results?

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